THE UNIVERSITY OF ALBERTA

THE EFFECT OF TIME LAPSE ON PATIENT SATISFACTION AND INCIDENT REPORTING

BY

MARIE NOWELL LYLE

A THESIS

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled THE EFFECT OF TIME LAPSE ON PATIENT SATISFACTION AND INCIDENT REPORTING submitted by Marie N. Lyle in partial fulfilment of the requirements for the degree of Master of Education.

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DEDICATION

This work is dedicated to the memory

of my grandfather

GORDON R. LYLE

whose kind and thoughtful ways

provided a shining star to follow

ABSTRACT

Four purposes were addressed in this study. They were to identify the level of patient satisfaction with the technical- professional, educational and trusting dimensions of nursing care; to examine personal and demographic variables which may affect the nature of satisfaction; to identify factors which influence the reporting of patients' opinions of the quality of care received; and to determine the effect of time lapse on the expressed level of patient satisfaction.

Data were collected using a questionnaire and an interview guide comprised of three sections related to: (1) personal data; (2) opinions of dimensions of nursing care; and (3) critical incidents and the related reporting behaviors. Data from sections two and three were collected prior to discharge and again either one or two weeks following discharge. Prior to being used in the investigation, the interview guide was pilot tested and revised. All data from the 49 completed and returned questionnaires and 52 interviews were analyzed.

Data were analyzed using frequency and percentage distributions to develop personal data profiles; *t*-test and one-way analysis of variance procedures were used to determine differences in opinions of respondents regarding satisfaction with dimensions of nursing care; correlated *t*-tests were used to determine the differences in opinions of respondents regarding satisfaction with nursing care prior to discharge and at follow-up; ranking of items by means was performed to identify

the effect of time lapse on the differences of opinions of respondents regarding satisfaction with dimensions of care; and categorization and frequency and percentage distribution were used to identify critical incidents and reporting behaviors.

Analysis of the data revealed that patients directly expressed an overall level of satisfaction with the nursing care, and time lapse had little effect on the level. Patients were satisfied with all aspects of patient teaching, the trusting relationship and technical-professional care. The two-week time lapse had no effect on the level of satisfaction expressed with technical-professional care while satisfaction with the trusting relationship and patient education declined.

Patients were able to identify and describe incidents which they perceived to have a positive and negative effect on their well-being as well as provide a rationale for their reporting behaviors. Psychosocial support measures were most frequently reported as positive-effect incidents, whereas, therapeutic interventions and no events were the most frequently reported negative-effect incidents. The majority of patients reported positive-effect incidents directly to the nurses involved, whereas the majority of patients did not report negative-effect incidents for affective reasons. The data revealed little substantive evidence relating personal and demographic data and satisfaction with care. Generally, married patients 50 years and over, who were receiving medical interventions, were more satisfied with the nursing care than their counterparts.

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CHAPTER ONE

STATEMENT AND IMPORTANCE OF PROBLEM

Introduction

This investigation was undertaken to directly measure patients' opinions about the technical-professional care provided by nurses, the educational aspects of that care, and the patients' trust in the nurses. Increasing attention is being paid to research about the patients' opinion of the health care received from health care practitioners. One reason for this attention is the belief that patient satisfaction is an important goal of health care delivery.

Despite the interest in obtaining the patient's perspective as a means of evaluating the care provided, health professionals have criticized the patient's "technical competence" to assess nursing, medical or health care services. However, it seems logical that patients are entitled to comment about and make demands on the relationship between themselves and the health professional. Further, if the care the patient expected is received, it would be anticipated that the patient would then be satisfied with the care provided.

A review of the research literature pertaining to patient satisfaction has indicated high levels of satisfaction with nursing, medical and health care services. The results of this research have led researchers to ask more questions than they have answered. The resultant questions are raised when realistically it is known that patients do have concerns and complaints about care which they perceive

to be lacking, inadequate or improper. Some questions raised as a result of these studies include whether or not the patient is reluctant to express negative opinions about health care providers, particularly if they are dependent upon them now or expect to be dependent upon them in the future. Patients of health care facilities supported by public funds may perceive the care they receive to be a benefit and not want to appear ungrateful. The location of health care facilities and the fact that physicians may not have affiliate privileges at other hospitals may increase the patient's feelings of dependence. If patients believe that they have offended the health care facility staff, alternate facilities may not be available.

Perhaps patients honestly report their perceptions about the care they receive but these perceptions may be distorted in a positive direction. Patients may over-estimate their satisfaction with the care provided. It is possible that aspects of care which were dissatisfying are removed in time and memory, and rated as satisfying.

The Problem

Four purposes for undertaking this investigation were identified. They were as follows:

1. To determine the level of patient satisfaction with the technical-professional and educational aspects of nursing care, and the level of trust which the patient has in the nurses providing care.
2. To examine personal and other selected variables which may affect the nature of patient satisfaction with nursing care.
3. To identify factors which may influence the reporting of the patient's opinion about the quality of care received.

4. To determine the effect of time lapse on the expressed level of patient satisfaction.

Nine hypotheses were posed as measures to test patient satisfaction with nursing care:

1. The level of satisfaction with nursing care expressed by adult patients will not vary with age.
2. The level of satisfaction with nursing care expressed by adult patients will not vary with gender.
3. The level of satisfaction with nursing care expressed by adult patients will not vary with marital status.
4. The level of satisfaction with nursing care expressed by adult patients will not vary with the experience of a surgical intervention.
5. The level of satisfaction with nursing care expressed by adult patients will not vary with attained educational level.
6. The level of satisfaction with nursing care expressed by adult patients will not vary with admission status.
7. The length of time between the most recent hospitalization and the present one will not have an effect on the level of satisfaction expressed by adult patients.
8. The level of satisfaction with nursing care expressed by adult patients who are health care workers will not vary from those patients who are not.
9. The level of satisfaction with selected aspects of nursing care expressed by adult patients will not vary from the day of discharge to that expressed at 7 days or 14 days following discharge from the hospital.

Importance of the Study

When patients express dissatisfaction with identified aspects of the nursing care received it becomes the professional responsibility of nursing administrators, educators and practitioners alike to further evaluate these comments. Besides evaluation, this responsibility extends to changing those aspects of care delivery when it is deemed reasonable and necessary for improving the quality of patient care.

Identifying variables which affect the patient's perception of satisfaction may provide insights for more accurate evaluation of health care services to occur. Further, if the patient's opinion of health care is to be considered valid by health professionals it is necessary to identify and remove those barriers which prevent the honest reporting of the patient's perception of the care received.

Delimitations, Limitations and Assumptions

Many delimitations pertained to the study. Individuals selected to participate in this investigation were adult patients who had been acutely ill on admission, experienced either a medical and/or surgical intervention, and were hospitalized for more than two and less than fourteen days. Respondents were required to be English literate, mentally competent and reside within a 25 mile radius of the City of Edmonton, and be accessible by telephone for fourteen days following discharge from the hospital. Individuals had to be willing to cooperate and sign a consent for inclusion in the investigation.

Furthermore, the respondents were selected from one large urban tertiary care hospital over a restricted period of time. Since patients, hospitals, interventions, and time periods were not randomly

selected the findings are not necessarily generalizable beyond this group of individuals.

The construct "satisfaction" has not been well formulated and/or measured in health care research. For the purposes of this investigation the assessment of patient satisfaction with nursing care was limited to specific nursing care measures which a patient could reasonably be expected to encounter while hospitalized. No attempt was made to develop a universally acceptable construct of satisfaction with nursing care.

The individuals who acted as face and content validators were not randomly selected. Again, the lack of random selection limits the generalizability of the reported face and content validity estimates.

A modified after-only time series design with random assignment was utilized to examine variables which were hypothesized to affect the level of patient satisfaction. This design did not permit identification and/or comparison of patient's expectations of nursing care prior to hospitalization.

Accordingly, several assumptions have to be made regarding the representativeness of the various groups if generalizations are to be made: individuals selected to participate were characteristic of the acutely ill medical and/or surgical patients of at least the one health care institution studied; face and content validators were representative of their respective groups; and, non-respondents were not atypical thus enabling respondents' answers to be generalizable.

As the construct "satisfaction" is not universally accepted, additional assumptions have been made to enable generalization: responses were based upon the individual's personal perception of

satisfaction or dissatisfaction with the nursing care received; and, the perception of satisfaction or dissatisfaction with nursing care will vary among individuals.

Definition of Terms

Several terms have been defined for the purposes of this investigation.

Acute Illness — A pronounced deviation from the normal healthy state; a physical disorder marked by severe symptoms over a relatively short period of time.

Dissatisfaction — The opposite of satisfaction, that is, the perception that expectations, needs, or desires have not been fulfilled.

Elective Admission — Entry into hospital is determined by the choice or decision of the patient and/or attending physician for procedures which are advantageous to the patient but not immediately necessary to save his/her life.

Emergency Admission — Entry into hospital is determined by the decision of the patient and/or attending physician, for an urgent situation which requires a quick intervention, either to save a life and/or to prevent further complications.

Health Care Worker — An individual who has graduated from a recognized health related eductional program and is providing, or has provided health care services.

Medical Intervention	Any action taken which pertains to the management of a disease in all of its aspects; pathology, diagnosis, prevention and treatment by other than surgical or obstetrical means.
Mentally Competent	Able to perform the ordinary affairs of life, understand their nature and effect, and exercise the will in relation to them.
Patient	Any adult individual who has been admitted to a tertiary care hospital.
Satisfaction	A perception that expectations, needs, or desires have been fulfilled.
Surgical Intervention	An operative procedure performed under a general anaesthetic in which penetration of the subcutaneous tissue occurs.

Overview of the Thesis

In the following chapter a review of related literature and research relevant to quality assurance and its assessment, patient satisfaction with health care services and nursing care, patients' rights in health care, and quality assessment techniques are presented. Chapter III comprises a description of the specific methodology and data analysis used in this investigation. The descriptive research findings and discussions are delineated in Chapter IV, while the analytical research findings and pertinent discussions are provided in Chapter V. The final chapter contains a summary of, conclusions and recommendations arising from the investigation.

CHAPTER TWO

REVIEW OF RELATED LITERATURE AND RESEARCH

This chapter contains a review of the literature and research as it relates to patient satisfaction and the methods used in this study to measure it. The chapter is divided into four sections. Section one defines and describes quality assurance, various approaches to its assessment and the impact that patients can have upon it. Section two reviews the theory and construct definition of satisfaction and methodological issues related to its measurement. Satisfaction research, both general and specific to health care services and nursing, is reviewed along with the findings of sociodemographic variables as they relate to the sample populations. The third section deals with the four Canadian patient rights in health care. Their ethical and legal considerations for health care providers and implications for nurses providing care are discussed. The last section deals with the two research instruments used to assess the patients' perception of the quality of care they received during this study. The literature and related research relevant to these instruments are reviewed.

Quality Assurance

Interest in the quality of health and medical care has been increasing among health care providers, recipients, and the public since the 1960s. This interest has been stimulated by a variety of social, political, economic and legal pressures. The interest has grown despite

a limited ability to define quality, to accurately assess the quality of health care and to effect the changes needed to assure quality (Graham, 1982).

Definitions

Quality assessment means measuring the level of care at some point in time, but implies no effort to change or improve that level of care. In contrast, quality assurance includes the level of care provided and, when necessary, the attempt to improve it (Brook, Williams and Davies-Avery, 1975).

The definition of quality is difficult to confine and still do justice to all its dimensions. Consumers may judge quality by the ability of the physician to make a diagnosis and the nurse to give an injection. Administrators may judge quality by the hospital's ability to deliver the greatest number of services at the lowest possible costs.

The definition of quality encompasses both the technical, scientific aspect and the art of care. The art of care refers to the manner in which providers conduct themselves in relation to their patients. The values of the professionals, the patients and the institution must be examined. As well, the purpose of the review must be identified. Is the purpose of the review to contain costs or to satisfy review requirements by some outside agency? Or is it to obtain information that can be used in making decisions about the improvement of care? A definition of quality, then, must take into account perspectives, values, and purpose. Furthermore, the definition of quality is dynamic. It changes as knowledge, values and resources change (Graham, 1982).

Donabedian (1980) argues that quality is a property of, and a judgment upon a definable unit of care, and that care is divisible into at least two parts: technical and interpersonal. The degree of quality of technical care is the extent to which care provided is expected to achieve the most favorable balance of risks and benefits. The interpersonal relationships must meet socially defined values and norms that govern interactions of individuals. These norms are reinforced by professional ethics and by the expectations of individual patients. The degree of quality of interpersonal relationships is measured by the extent of conformity to these values, norms, and expectations.

Donabedian (1980: 5-6) then defines quality of care as

> that kind of care which is expected to maximize an inclusive measure of patient welfare, after one has taken account of the balance of expected gains and losses that attend the process of care in all its parts. This concept is fundamental to the values, ethics, and traditions of the health professions: at the very least to do no harm; usually to do some good; and ideally to realize the greatest good that is possible to achieve in any given situation.

Approaches to Quality Assessment

Several approaches to quality assessment are documented in the literature (De Geyndt, 1970; Donabedian, 1966; Donabedian, 1980; Dror, 1968; Sheps, 1955). The Donabedian approach will be described here as it provides a useful way of organizing one's thinking about quality assessment and monitoring. Donabedian utilizes a tripartite division of structure, process and outcome to describe quality assessment. Although each aspect of the triad will be defined, ambiguities result from condensing what is in reality a series of unclear but causally related

elements (Donabedian, 1980). These elements are not attributes of quality, but approaches to the acquisition of information about the presence or absence of the attributes that constitute or define quality.

Structure. The concept of structure includes the human, physical, and financial resources that are needed to provide health care. More specifically, structure includes the number, mix and qualifications of staff; the manner in which the staff is organized and governed; space; equipment; other physical facilities and so on.

The use of structure as an indirect measure of the quality of care is relevant in that it increases or decreases the probability of good performance. The usefulness of structure as an indicator of the quality of care is limited because of insufficient knowledge about the relationship between structure and performance. The relative stability of structure makes it unsuitable for continuous monitoring although it should be checked intermittently to provide a judgment on whether care is provided under conditions that are conducive to or detract from the provision of good care (Donabedian, 1980).

Process. The set of activities that occur between providers and patients is the primary objective in the study of quality of care. This set of activities is the process of care. The basis for the judgment of quality is what is known about the relationship between the characteristics of the caring process and their consequences to the health and welfare of the patients and society, in accordance with the value placed upon health and welfare by the individual and by society.

The standards of technical care are based upon the state of medical science and technology at any given time. The standards governing the interpersonal process arise from the values, ethical principles and rules that govern the relationship among people, in general, and between health professionals and patients, in particular. Therefore, the quality of the process of care is defined as normative behavior. The norms are derived either from the science of medicine or from the ethics and values of society.

The process approach to studying quality of care utilizes direct observation of practice, or studies based on the patient care record looking for the presence or absence of critical elements of care, or audits using explicit or implicit criteria. The direct observation of practice is costly and time consuming. It may also alter the behavior being observed. The analysis of patient care records is less obtrusive, but its limitations lie in the completeness and accuracy of the record (Donabedian, 1980).

Outcome. The outcomes of care are primarily changes in health status that can be attributed to that care. Health status can be viewed narrowly as physical or physiological functions or more broadly, to include psychological function and social performance (Breslow, 1972). An encompassing view includes changes in health-related knowledge, patient attitudes including satisfaction, and the health-related behavior changes of the patient (Donabedian, 1980; Sanzaro and Williamson, 1968; Starfield, 1974).

As an indirect measure of quality of care the outcome approach allows us to view the immediately discernible results of that care. Once it has been established that certain procedures used in specified situations are clearly associated with good results, the mere absence or presence of these procedures in these situations can be accepted as good or poor quality (Donabedian, 1980). Studies of outcome include morbidity, disability, mortality of communities and populations, postoperative mortality and morbidity, preventable adverse effects, preventable progression of disease, and so on.

The tripartite approach to quality assessment indicates the presence of a functional relationship among the three elements, which can be shown schematically as follows:

STRUCTURE ⟶ PROCESS ⟶ OUTCOME

This suggests that structural characteristics of the care setting have a propensity to influence the process of care so that its quality is diminished or enhanced. Similarly, changes in the caring process, including variations in its quality, will influence the effect of care on health status (Donabedian, 1980).

Patients and their Impact on Quality

Patients, individually and collectively, contribute to the definition of quality. Donabedian (1980) suggests that these contributions include: (1) influencing what is included in the definition of health and health care; (2) determining the valuations placed on the expected benefits and risks to health; and (3) their values and expectations regarding the interpersonal process.

Patient satisfaction can also be regarded as the patient's judgment on the quality of care. Even though patient and professional judgments may utilize different views/criteria and the conclusions may differ, patients' judgments represent their assessment of care. The patient's assessment could pertain to the settings and courtesy of care, to aspects of technical management, to interpersonal care, and to the physiological, physical, psychological, or social consequences of care (Donabedian, 1980).

As a measure of quality of care, patient satisfaction is notable because it provides information about the provider's success at meeting the patient's values and expectations which are matters for which the patient is the only authority. The measurement of patient satisfaction with care, then, is an indispensable tool for health research, administration and planning. Informally, patient satisfaction can be used formatively by the provider to monitor and guide the interaction and summatively to evaluate the success of the interaction (Donabedian, 1980).

Patient satisfaction has some limitations as a measure of quality. Patients generally have an incomplete understanding of the science and technology of care, so their judgments of these aspects of care may be unreliable. Patients sometimes expect and demand things which would be inappropriate for the practitioner to provide because they are professionally or socially wrong, or because they are not in the patient's best interest. However, these limitations do not decrease the validity of patient satisfaction as a measure of quality. For example, if the patient is dissatisfied due to high expectations about the

results of a procedure, one could argue that the provider failed to educate the patient (Donabedian, 1980).

Donabedian (1980) demonstrates that these considerations, collectively, relate patient satisfaction to quality in numerous ways. To the extent that patient satisfaction:

1. is a direct benefit of care it is also a part of the balance of benefits and harms which is encompassed in the definition of quality;
2. contributes to other benefits such as access to care or compliance, it can be measured more directly;
3. is a judgement of the quality of care, it best represents those components of the definition of quality which pertain to patient expectations and values.

Patient Satisfaction

Much of the satisfaction research has focused on the construct either as the dependent variable to evaluate facility and service characteristics assuming that patient satisfaction is an indicator of structure, process and outcomes of care, or as an independent variable to predict subsequent behaviors assuming that differences in satisfaction influence what people do (Ware, Davies-Avery, Stewart 1978). In either case, the research has been primarily problem-oriented; its purpose is to provide data on the basis of which practical conclusions can be drawn by administrators, practitioners and consumer groups in a variety of health care settings. Very little of the satisfaction research has been theory-testing or theory-building; that is, research designed to provide data that would explain the

association between satisfaction and facility and service characteristics, or between satisfaction and subsequent behaviors. This lack of attention or lack of consistency in labelling the construct has been mentioned in reviews of the patient satisfaction literature (Locker and Dunt, 1978; Ware et al., 1978). A few exceptions include: Gerst, Rogson and Hetherington (1969); Linder-Pelz (1982); Linn (1975); Pope (1978); Tessler and Mechanic (1975); and Wriglesworth and Williams (1975).

A comprehensive and critical review of the literature by Ware et al. (1978) concluded that the published empirical studies of patient satisfaction dealt with a large number of items which could be grouped according to the dimension which they were implicitly intended to measure. There were ten dimensions identified: accessibility/convenience, availability of resources, continuity of care, efficacy/outcomes of care, finances, humaneness, information gathering, information giving, pleasantness of surroundings, and quality/competence.

This content analysis informs us of the multi-dimensionality of the phenomenon, patient satisfaction, but it does not answer the key question: what is satisfaction? A similar lack of conceptualization of client satisfaction research in public agencies, programs and services is reported by Gutek (1976). The largest body of theoretical and empirical studies of satisfaction are in relation to jobs and work.

"We need to understand the concept of satisfaction before we can really explain why certain factors cause it and others are caused by it" (Lawler, 1971:206). Although this comment was made in relation to the

study of pay satisfaction it is generalizable to other satisfactions. The concept, satisfaction, appears to be both complex and complicated.

Initial research efforts attempted to describe a relationship between personal attributes and degree of happiness (Hartman, 1934; Sailer, 1931; Watson, 1930). Various aspects of job satisfaction have received considerable attention (Hertzberg, 1966; Hulin, 1977; Lawler, 1971; Locke, 1979). Hertzberg, Mausner, and Snyderman (1959) determined that intrinsic aspects of the job, such as responsibility and recognition, influenced satisfaction whereas extrinsic factors such as wages and policies, influenced job dissatisfaction. Maslow (1965) and McGregor (1960) studied job satisfaction applying a "needs" framework, suggesting that people seek to satisfy unfulfilled needs through work.

Towards building a theory of patient satisfaction Linder-Pelz reviewed the sociological and social psychological literature, and advanced the conceptual definition of patient satisfaction as "the individual's positive evaluation of the distinct dimensions of health care (s)he experienced" (1982a: 580). Further, four social psychological variables -- expectations, values, entitlement, and perceived occurrences -- were hypothesized as probable determinants of satisfaction (Linder-Pelz, 1982a). In a subsequent study Linder-Pelz (1982b) found that:

1. the social psychological variables together explained less than 10 percent of the variance in satisfaction;
2. expectations consistently explained most of the variance in satisfaction ratings;

3. values had little independent effect on satisfaction, and the combinations of values and expectations (their interaction) was unrelated to satisfaction;
4. the linear discrepancy between expectations and occurrences, which take into account the strength of the expectations, is negatively correlated with satisfaction; and
5. satisfaction is greater among patients with both favorable expectations and favorable occurrences than among patients with favorable expectations but negative occurrences, and least among those with both negative expectations and negative occurrences.

Further consideration in the development of a multivariate model of patient satisfaction would include other social psychological determinants, patient's demographic data or health variables, and characteristics of the health care system or providers of care that would likely affect patient's evaluation of care.

Although health professionals display interest in the patient's perspective as a method of evaluating the care provided there are several difficulties. Beyond issues such as the diversity of settings, populations, measurement techniques, and elements of satisfaction there is a lack of a sound methodological basis in the majority of reported studies (Lebow, 1974; Linn, 1975; Locker and Dunt, 1978; Ware et al., 1978).

Methodological Issues

A major methodological issue is related to the tools developed to assess patient satisfaction. The majority of researchers assessing patient satisfaction with nursing and medical care or health care

services have failed to determine the reliability and validity of the tool to measure what it claims to measure (Apostle and Oder, 1967; Patient Attitude Survey, 1979; Pollert, 1971; Raphael, 1967). When initially fielding a tool the essential minimal criteria are reliability and validity data of the measurement device (American Psychological Association, American Educational Research Association and National Council on Measurement in Education, 1974). Not only are such data necessary in order for the reader to be able to utilize the tool correctly but also for other researchers to further develop, refine, and apply the tool in the same and related areas of study. A few researchers have dealt with some of these psychometric aspects, such as Hulka, Zyzanski, Cassel and Thompson (1970); Ware and Snyder (1975); and Zyzanski, Hulka and Cassel (1974).

For the majority of studies there is a persistent lack of a standard approach to the measurement of patient satisfaction (Locker et al., 1978). Lebow (1974) and Linn (1975) proposed various hindrances to the development of a standardized approach to assessing patient satisfaction. First, the source of populations have varied. Researchers have studied various inpatient groups within the hospital (Geertson, Ford and Castle, 1976; Kirchhoff, 1976; Nehring and Geach, 1973), clinic patients (Francis, Korsch and Morris, 1969; Korsch, Gozzi and Francis, 1968), and the community at large (Hulka, Kupper, Daly, Cassel and Schoen, 1975; Koos, 1955).

A second but distinct issue is the many diverse settings in which health care services are provided (Lebow, 1974). These studies focus on the particular attributes that differentiate one setting from another (Houston and Pasanen, 1972; Noyes, Levy, Chase and Udry, 1974; Pollert,

1971; Tessler et al., 1975). The differences among populations and settings appear to hinder construction of a patient satisfaction measurement tool which is universally acceptable.

The third issue is related to the number of techniques used to measure satisfaction with health care (Linn, 1975). Ware et al. (1978) determined that many researchers have used single-item measures, such as Henley and Davis (1967), although multi-item questionnaires are known to provide score variability such that statistical validity and reliability can be demonstrated. Locker et al. (1978) demonstrated discrepancies between subjects' responses to open-ended (allows freedom of choice) and closed-ended (elicits a "forced-choice" to alternatives) items without providing evidence that one form of enquiry was more valid than the other.

The fourth issue pertains to the phenomenon of satisfaction studied (Linn, 1975). To evaluate patient satisfaction with health care services, attention has centered on prepaid group practice/health care insurance plans (Donabedian, 1969; Gerst et al., 1969). With medical care, researchers have focused on a particular visit to the physician (Kisch and Reeder, 1969; Korsch et al., 1968); with nursing care, the concepts of team versus primary nursing (Daeffler, 1975) or the importance of selected nursing activities (White, 1972) have been studied. Despite this diversity few researchers have provided evidence that an adequate assessment of the construct satisfaction was developed.

The complexity of the construct satisfaction, the lack of a sound methodological basis and the limitations imposed by the four previously stated issues make it difficult, if not impossible, to compare the

numerous patient satisfaction studies. Nurse researchers studying this area do not necessarily solve any of these constraints.

Nursing Research

A majority of the studies of patient satisfaction which have been done by nurses have suffered from the absence of sound measurement strategies. The research done by Abdellah and Levine (1957a, 1957b, 1957c, 1957d, 1958) and Risser (1975) are exceptions. The Abdellah et al. (1957b) study was designed to identify omissions of care in nursing and non-nursing events. Study results indicated that many patients reported dissatisfaction with particular nursing activities: 64 percent of the patients expressed dissatisfaction with the amount of information provided by nurses and 47 percent believed nurses were slow to answer calls for assistance. Focusing upon nurses and nursing care, Risser (1975) also found patients were least satisfied with the information provided by the nurses. Pender's (1974) study found that the majority of patients felt that the physician provided the most useful information, while Wriglesworth et al. (1975) found that patients stated nurses gave the most helpful information in a post-operative situation. Articles by Clarke and Bayley (1972), Fournet (1974), and Powell and Winslow (1973) support the findings of the latter study.

White (1972) provided an indirect measure of patient satisfaction with nursing care by evaluating differing levels of importance between patients and nurses in ranking various nursing activities. Patients were more concerned than nurses about their hygiene and physical comforts. In contrast to patients, nurses placed more emphasis upon the psychosocial aspects of care. Further, patients and nurses agreed to

the importance of complying with the physician's plan of care and to the unimportance of activities relating to the preparation for discharge. This latter finding is in contradiction to Linehan's (1966) finding. Considering the value placed on patient education today one must question if patients and nurses would continue to rate discharge teaching as unimportant.

Of those studies in which an overall satisfaction with nursing care was reported (often on the basis of one item), the results ranged from 67 to 100 percent (Geertson et al., 1976; Pollert, 1971; Raphael, 1967). Support for these findings is also found in the medical and health care services research by Korsch et al. (1968), Pope (1978) and Tessler et al. (1975). High satisfaction responses were typical although patients stated they were dissatisfied with particular aspects of the care they received. It is unfortunate that in using a general satisfaction rating scale, data identifying specific instances of satisfaction and dissatisfaction are lost.

The Risser (1975) study format can be distinguished from the one used by Abdellah et al. (1957a). In the Abdellah et al. (1957b) study, 47 of the 50 items evoking omissions of care in nursing and non-nursing events were stated negatively; three, indicating satisfaction with care, were stated positively. Daeffler (1975) utilizing the Abdellah et al. (1957b) tool subsequently criticized this format. This investigator concurs with this criticism and questions why a more even distribution of positively and negatively stated items were not selected as suggested by Oppenheim (1966). In contrast to Abdellah et al. (1957b), Risser (1975) included similar numbers of positively and negatively stated items in an attempt to avoid response set bias. This strategy, when

incorporated into scale construction, increases the likelihood of obtaining trustworthy results as the subject, accustomed to responding typically regardless of item content, cannot inadvertently bias the data in this incidental manner (Polit and Hungler, 1978; Ware, 1978). Although item content determines what a test measures, it is the composite effect of both the content and form of the items that contributes to the final score (Cronbach, 1946). In Cronbach's (1946: 484) words, "response set always lowers the logical validity of a test . . . response set interferes with inferences from test data."

Sociodemographic Variables

In an effort to detect differences in general populations and the extent to which such differences exist, sociodemographic variables have been studied in patient satisfaction research. Ware et al. (1978) provide a review of the research relating several of these variables to satisfaction. In addition to, and specific to the hypotheses for this study, a further comparison is provided.

Older patients were reported to be more satisfied with care (Fleming, 1981; Gerst et al., 1969; Laing, 1977; Tremlett, 1977) while the opposite was found by Geertson et al. (1976) and no relationship was found to exist by Greenley and Schoenherr (1981). Gender was unrelated to satisfaction with care (Greenley et al., 1981), whereas males were reported as more satisfied (Geertson et al., 1976; Gerst et al., 1969) than females.

Married persons were more satisfied than the unmarried (Bashshur, Metzner and Warden, 1967; Geertson et al., 1976; Gerst et al., 1969), while Wriglesworth et al. (1975) found no relationship between marital

status and satisfaction with care. Gerst et al. (1969) and Geertson et al. (1976) found educational level to correlate positively with satisfaction, while Greenley et al. (1981) and Bashshur et al. (1967) found no relationship to exist.

Wriglesworth et al. (1975) found no significant relationship between admission status and satisfaction, while Tremlett (1977) found with traumatic admissions the number of critical comments doubled over those associated with elective admissions. Fleming (1981) found worry over the hospitalized condition had a negative relationship with satisfaction. Wriglesworth et al. (1975) found satisfaction not to be related to previous hospitalization whereas satisfaction expressed increased with those who had experienced previous hospitalizations (Geertson et al., 1976; Laing, 1977; Tremlett, 1977).

It is difficult to summarize the literature regarding patient satisfaction. Differences in sociodemographic variables may be due to true population differences in the relationships and/or to methodological problems and differences. The construct satisfaction has not been clarified despite the numerous investigations of its structure and application. However, there is little doubt that this lack of progress may be due to poor methodological vigor and/or a failure to systematically identify the confounding influence of numerous variables. Factors such as diverse populations, settings and measurement techniques appear to compound the difficult task of defining satisfaction in health care research.

Despite the use of disparate approaches to inquiry, a common finding of many studies is that patients have not been given adequate information about their health status and nursing care measures.

Indeed, patients have an unquestionable right to the very information they have not received. The following section comprises a review of the factors identified in the literature as belonging in the area of patient rights.

Patient Rights in Health Care

Following the depression and during World War II a growing concern for the need to protect human rights resulted in the Universal Declaration of Human Rights. In 1948, the declaration was adopted by the United Nations General Assembly as a statement of resolution reflecting international goals and aspirations (Ashner, 1957). Since that time, many countries, states and provinces have introduced bills in an attempt to promote human rights.

In 1960, an Act for the Recognition and Protection of Human Rights and Fundamental Freedoms, commonly known as the Canadian Bill of Rights was passed by the Parliament of Canada. Although the Act's legal significance was minimal, it demonstrated awareness and concern for human right violations within Canada (Brett, 1969; MacGuigan, 1965; Schmeiser, 1964). It was not until 1982, when the Canadian Constitution was proclaimed that the Charter of Rights and Freedoms for Canadians became legally entrenched into Canadian society (Storch, 1982).

In the late 1960s and early 1970s consumer organizations and various other human rights groups began to advocate the concept of citizen participation in the planning, implementation and evaluation of social welfare programs (Guest, 1982). At the same time, interest in consumer rights in health care was reflected in both the United States of America (U.S.A.) and Canada. In the U.S.A. the American Hospital

Association issued a twelve-point Statement on a Patients' Bill of Rights in 1972.

In Canada a statement was published in 1974 by the Consumer's Association of Canada entitled "Consumer Rights in Health Care" outlining four consumer rights. The statement reads as follows:

I. RIGHT TO BE INFORMED

- about preventive health care including education on nutrition, birth control, drug use, appropriate exercise
- about the health care system including the extent of government insurance coverage for services, supplementary insurance plans, the referral system to auxiliary health and social facilities and services in the community
- about the individual's own diagnosis and specific treatment program including prescribed surgery and medications, options, effects and side effects
- about the specific cost of procedures, services and professional fees undertaken on behalf of the individual consumer

II RIGHT TO BE RESPECTED AS THE INDIVIDUAL WITH THE MAJOR RESPONSIBILITY FOR HIS OWN HEALTH CARE

- right that confidentiality of his health records be maintained
- right to refuse experimentation, undue painful prolongation of his life or participation in teaching programs
- right of adult to refuse treatment, right to die with dignity

III RIGHT TO PARTICIPATE IN DECISION MAKING AFFECTING HIS HEALTH

- through consumer representation at each level of government in planning and evaluating the system of health services, the types and qualities of service and the conditions under which health services are delivered

- with the health professionals and personnel involved in his direct health care

IV RIGHT TO EQUAL ACCESS TO HEALTH CARE (HEALTH EDUCATION, PREVENTION, TREATMENT AND REHABILITATION) REGARDLESS OF THE INDIVIDUAL'S ECONOMIC STATUS, SEX, AGE, CREED, ETHNIC ORIGIN AND LOCATION

- right to access to adequately qualified health personnel
- right to a second medical opinion
- right to prompt rescue ~~in~~ emergencies.

Right to be Informed

Legally and morally, patients have the right to be informed. Tort law provides the legal basis for the patients' right to informed consent for treatment. This means that patients have the right to make decisions, based on adequate information about their care and treatment, without coercion. The ethical principles of autonomy, veracity, paternalism and beneficence provides the basis for the patients' right to be treated as an individual and told the truth (Storch, 1982).

Autonomy is the ability to freely determine a choice of action (Beauchamp and Childress, 1979). Patients must receive enough information to make a decision in a reasoned way. Health professionals are obligated to respect those decisions even if they disagree with them. The principle of veracity requires that health professionals ensure that the necessary and accurate information is provided to the patient; it is the necessary basis for establishing a trusting relationship. The concepts of paternalism and beneficence, involve placing restrictions on patients' freedoms justified by the belief that it is a professional duty and in the patients' own best interest

(Davis, 1981; Dworkin, 1976; Gert and Culver, 1976). Although health professionals frequently find themselves in a paternalistic role, any paternalistic intervention must be carefully considered for its justifications and limitations.

The right to be informed encompasses information about preventive health care, the health care system, the individuals' health care status and the costs of health care (Consumers' Association of Canada, 1974). Nurses employed in hospital settings primarily provide information to patients about the health care system and their health care status.

Patients' ability to interact with the health care delivery system leads to more effective health care. Information about personnel, organization and structure, routines and procedures, and norms and expectations enhances the individual's confidence to manage himself/herself in the patient role in what is a seemingly impersonal health care system (Narrow, 1979). This need to feel confident in an often unfamiliar role is closely related to the need for physiological safety, the need to belong, and the need for self-esteem (Narrow, 1979).

Patients have the right to know as much as desired about their health care status. Who provides this information is often unclear. Various health professionals interact with patients and provide education. Harper (1976) recognized that patient education is too complex for any one discipline to assume total responsibility. It is a recognized role and responsibility of physicians to provide information about the medical and/or surgical treatment, diagnosis, and results of diagnostic studies (Alberta Hospital Association, Alberta Association of Registered Nurses, College of Physicians and Surgeons, Alberta Medical Association, 1984).

Narrow (1979) identified six areas of information that nurses should provide to patients. They include language and terminology, anatomy and physiology, nursing diagnosis and prognosis, treatments, predictable events, and information about nursing procedures being performed. Accurate and understandable information provided in these areas is the basis by which patients can autonomously make decisions in a reasoned way.

The breadth and depth of the information which should be provided to the patient is often unclear. For example, informed consent is an area of much medical and legal controversy. How much information is necessary for a consent to be considered to be an informed one? Several legal cases have set the precedents for legal decisions and have influenced hospital policies. These cases determined that informed consent required "that the patient be told enough about the treatment, the alternatives, and the inherent risks of the treatment to make an intelligent choice" (Wing, 1976: 113). Further, the patient must be informed in non-technical terms, and the duty to inform does not depend on the patient's requesting the information (Institute of Law Research and Reform, 1975). Although Chief Justice Laskin specified a full disclosure standard (Picard, 1981), health professionals recognize many factors which impinge upon the amount of information provided. The patient's age, ability to comprehend, physical, mental and emotional condition, and interest or desire to understand affects the amount and method of information provided by the health professional (Storch, 1982).

The nurse must be alert to evidence of misunderstanding by the patient or health professionals. The most important source of information for health professionals is the patient. The entire process of diagnosis and medical and nursing interventions depends on reliable and accurate information provided by patients (Rushmer, 1975). At the same time, health professionals must listen to patients' complaints and comments (Catlin, 1981). Therefore, teaching which enhances patient proficiency in providing accurate information, and the development of listening and other communication skills for health professionals must be recognized and encouraged (Storch, 1982).

Nurses are in a unique role to provide the patient with information because of their knowledge, opportunity to teach, and the nature of the nurse-patient relationship. Firstly, nurses have knowledge of physiological conditions, treatments and outcomes and the health care delivery system (Baden, 1977). Secondly, the nurse spends more time with the patient (Lyons, 1977) and is better able to assess his/her need and readiness to learn (Narrow, 1979). Thirdly, the nurse is able to individualize the teaching to the patient and make it relevant (Narrow, 1979) and, finally, teaching is an accepted part of the nursing role.

Despite the acceptance of patient teaching as a nursing role and the legal accountability for teaching, it frequently does not occur to any extent. Numerous factors have been reported as barriers to patient education efforts (Pohl, 1965; Redman, 1976). For example, lack of preparation to teach (Winslow, 1976), lack of knowledge (Jenny, 1978), lack of nursing service support (del Bueno, 1978), and patient's failure to ask for information (Winslow, 1976) are barriers commonly cited.

Nurses are with patients 24 hours a day and are in a position to play the role of advocate, negotiator, and teacher. The nurse is able to: (1) assess the patient's understanding of the treatment, risks, and alternatives; (2) inform other health professionals when the patient has not understood, and to arrange for further discussion; (3) identify and bring to the attention of others instances where non-valid consents have been given (Registered Nurses Association of British Columbia, 1980); and (4) provide information directly to the patient.

The nursing profession and nurses themselves need to overcome any barriers which prevent patients from receiving necessary information. Withheld information could potentially be detrimental to the patients' well-being as well as infringe upon their rights. Therefore, nurses and other health professionals "must share information and collaboratively advance sound, successful patient education" (Johnson, 1978: 5).

Right to be Respected

The right to be respected is composed of three dimensions. These dimensions include the right to: (1) confidentiality of health records; (2) refuse experimentation, undue prolongation of life or participation in teaching programs; and (3) refuse treatment and to die with dignity. Overall, health care consumers are asking for the right to be treated as individuals responsible for their own health (Consumers' Association of Canada, 1974).

The concept of respect is related to the principles of autonomy, non-maleficence and beneficence (Storch, 1982). These principles imply that individuals should have the freedom of choice and that action toward others should contribute to their well-being and not cause

harmful effects. Although respect is primarily a moral right there are certain legal regulations in effect, especially as related to confidentiality and refusal of treatment.

The rights to privacy and confidentiality are closely related. In Canada, the provinces of British Columbia and Manitoba have had Privacy Acts legislated (Sklar, 1978). It seems inconceivable that the right to privacy requires a law, yet privacy is a frequently overlooked but important factor in the recovery from an illness episode. In many health care facilities neither the physical structure nor the hospitalization process is conducive to privacy. This is reflected by large open area emergency departments or nursing units where various health professionals examine and question patients. Frequently these activities are of a highly personal nature and permission from the patient has not been sought (Storch, 1982).

The professional-patient relationship implies a duty or responsibility to each other. In fact part of the nursing process is to encourage the patient to express himself freely, and to share his problems with the nurse (International Council of Nurses, 1977). It is also more likely that patients will divulge information if they are assured that the information will be kept in confidence (Sklar, 1978). Confidentiality is clearly recognized within nursing as an ethical duty to patients as evidenced by the Florence Nightingale Pledge (1893), the International Council of Nurses Code of Ethics (1953), and the Alberta Association of Registered Nurses' Code of Ethics (1983). In addition, the patient's right to confidentiality is protected by provincial statute (Alberta Hospitals Act, 1980).

Health professionals need to heighten their sensitivity towards patients' need for privacy and confidentiality. They can remind others of the patients' need for privacy and be more respectful and caring themselves. Health professionals must be careful not to share information too freely and to avoid gossip. They must respect professional obligations in regard to the privacy of and information about patients.

Nurses' fundamental responsibilities are threefold: to conserve life, to alleviate suffering and to promote health (International Council of Nurses, 1953). However, they must be cautious about coercing patients to receive treatments if the patient refuses. This applies not only to refusal of treatment, but also the refusal to be involved in experimentation or as a teaching subject. The right to be respected as an individual with the responsibility for his/her own health provides the right of self-determination. Whether or not the patient participates in treatment, teaching or research the patient retains the right "to be adequately informed . . ., to have their privacy respected, and to be protected from undue risk to either their physical or emotional well-being" (Downs, 1979: 131).

If the nurse believes that the patient is making a wrong decision, he/she may evaluate the basis upon which the refusal was made. If the refusal was due to fear or lack of understanding the nurse can help the patient deal with the fear or provide any information necessary for the patient to understand. However, if the patient is a competent adult his/her decision must be respected (Storch, 1982). As Storch (1982: 91) states

> nurses can monitor, support, intervene, and advocate for considerate and respectful care, privacy, confidentiality, appropriate use of human subjects in teaching and research, respect in cases of refusal of treatment, and dignity in dying.

Right to Participate

The consumers' right to participate in decision making involves both decisions about their own direct health care and the planning and evaluation of health care services (Consumers' Association of Canada, 1974). This right also implies an obligation to participate and is based on the principles of autonomy and responsibility (Storch, 1982).

"Patients are treated as passive recipients of the ministrations of health professionals in health education, in nursing care planning, and in intervention strategies" (Storch, 1982: 100). "Despite unprecedented advances in knowledge and technology . . . people have never been more disillusioned and discontented with health care delivery . . ." (Brody 1980: 718, 722).

The degree to which patients will participate will be influenced by the severity of the illness and their capabilities and emotional responses (Kalisch, 1973). Health professionals take an active dominant role during times when patients are comatose, confused, or critically ill. However, they must be prepared to relinquish this role when patients are able to actively participate in their own care. Health professionals can and should facilitate and encourage patients to actively participate in their care (Davis, 1980).

In any patient-health professional relationship there is an element of dependency of the patient upon the health professional. This is especially so with the patient-physician relationship. The physician's

power over the ill individual is so great that it has been labelled "aesculapian authority" (Kalisch, 1979; Paterson, 1966; Seigler and Osmond, 1973). The nurse-patient relationship is less power oriented and more of a helping relationship (Kalisch, 1973; Orem, 1980). The trend in nursing is to move patients away from the passive-dependent role to one where they assume an active responsible role. This is evidenced by the growing literature advocating self-care and the development of a self-care model for nursing practice (Orem, 1980) that emphasizes patient participation. The Alberta Association of Registered Nurses' Standards of Practice (1980) clearly indicates that patient participation during each phase of the nursing process, namely, assessment, planning, implementation and evaluation of care is necessary.

Patient participation implies that they should evaluate the care they receive and the way in which it was delivered. Obtaining patients' evaluation of care is often difficult not only because some patients fear reprisal and therefore will not make negative comments (Nehring et al., 1973), but their level of satisfaction is not easy to measure (Ware et al., 1978).

Consumer participation at the community level, once an accepted activity, became limited as the population grew and society changed (Storch, 1982). Several problems appear to restrict meaningful participation. These include lack of consumer interest (Feingold, 1974; Hepworth, 1976; Klein, 1972), complex structural features of the system (Paap, 1978; Van den Heuval, 1980), difficulty selecting and training consumers (Storch, 1982), and lack of confidence of consumers which is

frequently reinforced by the health professionals (Christensen and Wertheimer, 1976; Steckler and Herzog, 1979; Stoller, 1977).

One crucial function of consumer participation is to counter paternalism of health professionals (Storch, 1982). Hepworth (1976) argues that consumers can identify health care needs and inadequacies of the system, limit the bureaucratic nature of organizations, make services more responsive and watch over standards of practice and service. However, differences between the parameters considered important by consumers and health professionals exist (Kelman, 1976). Kramer (1973: 577-578) suggested that "health professionals must be taught to value the participation of the consumer."

It is believed that consumer participation on hospital and nursing committees would provide greater accountability (Storch, 1982). They could serve on patient care, policy, quality assurance, and staff development committees, as well as be involved in activities such as reviewing incident reports and standard setting (Lewis, 1980; Storch, 1982). Consumers are also beginning to participate in the professional nursing associations. The Canadian Nurses' Association, the Alberta Association of Registered Nurses, and other provincial associations involve consumers in various ways on their governing councils and disciplinary review boards.

Right to Equal Access

The right to equal access to health care regardless of the individual's economic status, gender, age, creed, ethnic origin, and location, includes the right to access to qualified health personnel, a second medical opinion, and prompt rescue in emergencies (Consumers' Association of Canada, 1974).

There appears to be little mention of patients' rights to equal access to health care in the literature. However, the right to non-discriminatory care is widely accepted. There is little dispute over the need to improve access to health care services for the poor (Reynolds, 1976) and racial minority groups (Okada and Sparer, 1976), as well as to improve the balance between primary, secondary and tertiary care (Battisella, 1976).

Governments have attempted to distribute medical services into underserviced areas. In return for a commitment to work in underserviced areas, medical students have been subsidized (Mason, 1971) and physicians have been given bonuses (Copeman, 1973). These attempts have had limited success.

Governments have dealt with consumer concerns regarding the qualifications of health personnel primarily by authorizing licensing to professional associations like the Alberta Association of Registered Nurses (Alberta Nursing Profession Act, 1983) for the purpose of guaranteeing standards of quality and service (McLeod, 1973). Hospital activities and employed personnel are also monitored through accreditation activities which compare hospital practices to established minimum standards of care (Canadian Council on Hospital Accreditation, 1985).

The right to a second medical opinion and to prompt rescue in emergencies may be less known. However, basic nursing education curriculums require the American Heart Foundation's (1986) cardiopulmonary resuscitation program and patients within hospital settings do expect promptness in response to calls for assistance.

Quality Assessment

The literature describing two approaches used for this investigation is presented. A brief examination of previous questionnaire development and validity and reliability measures is included. The methodology and definitions relating to critical incidents are also discussed.

Patient Satisfaction Questionnaire

The Risser Patient Satisfaction questionnaire (1975) was developed to study evaluation of nurses and nursing care in ambulatory primary health care settings from the patient's perspective. Risser (1975) suggested that the dimensions of satisfaction logically related to nursing care in the ambulatory health care areas included: (1) the personalities of the nurses and the nurse-patient relationship; and (2) the nurse's professional competence and the patient's perception of the quality of nursing care received. Other dimensions of care, as subsequently described by Ware et al. (1978), seemed more appropriate when measuring satisfaction with medical care or with the overall health care delivery system.

Studies by Gorham (1962), Holliday (1961), and Tagliacozzo (1965) provided support for these dimensions of satisfaction with nurses and nursing care provided. Tagliacozzo (1965) interviewed patients to determine their satisfaction with nursing care in hospitals and found that 81 percent of patients stressed the importance of personal care; 81 percent emphasized personality attributes of the nurse; 45 percent expected prompt, efficient services; and 29 percent mentioned specifically that they expected knowledge and technical skills to be conveyed.

Risser's (1975) conceptual framework defined patient satisfaction as an evaluation criterion for health care in general and nursing care in particular. Whether patient satisfaction should be considered a process or outcome criterion was not clarified (Bloch, 1980; Donabedian, 1980). To develop the instrument, attitude measurement methodology was applied. The Likert method was selected because of relative ease of administration and scoring, relative simplicity of construction, potential reliability with relatively few items, and relationship to behavioral criteria (Guilford, 1954; Likert, 1932; Oppenheim, 1966; Tittle and Hill, 1967).

The dimensions and definitions which Risser (1975: 47) used to guide scale and item development were:

> Technical-professional behavior of the nurse which fulfills instrumental or goal achievement functions, for example, nurse knowledge, physical care for patient, and expertise in implementing medical care.
>
> Intra-interpersonal. The expressive function of the nurse. Intrapersonal. The nurse's personality characteristics, for example, appearance, friendliness, confidence. Interpersonal. Social aspects of nursing care.
>
> Trusting relationship. Verbal and non-verbal communication measures, for example, interest in patient, sensitivity to people and their feelings, and listening to patient problems.
>
> Educational relationship. Information exchange between patient and nurse, including such activities as answering questions, explaining and demonstrating.

Items for the preliminary questionnaire were obtained from interviews with patients, literature review, judgements of experts and questionnaires concerned with patient satisfaction with physicians and medical care and nursing care in hospitals (Risser, 1975). An attempt was made to use terminology which approximated that which patients themselves use (Remmers, 1954). Phrases related to feelings were

included but factual items were avoided (Oppenheim, 1966; Shaw and Wright, 1967). Simple and clear language was used to convey a single idea in each statement. Roughly equal numbers of positive and negative items were included in an attempt to avoid response set bias (Edwards, 1970; Oppenheim, 1966; Scott, 1968).

The questionnaire was submitted to two sequential trials which resulted in 138 usable returns. The original 58 item questionnaire was revised down to a 25 item questionnaire following application of absolute and relative frequencies and the internal consistency measure of inter-item correlation coefficients (Risser, 1975). Items from the intrapersonal dimension seemed to correlate equally highly with groups of items in other clusters. The items from the intrapersonal dimension were incorporated into other areas judged appropriate by the correlation coefficients and item content (Risser, 1975).

Scale homogeneity ratios (Scott, 1968), reliability coefficient alphas (Cronbach, 1951), and intersubscale correlation coefficients were obtained from the data. The revised questionnaire, both as a whole and the subscales, evidenced an ability to discriminate between persons of various relative satisfaction levels. Maximum possible range for mean scores spread from 1.0 to 5.0 (Risser, 1975).

Individual scores were positively skewed. Risser (1975) suggested the skewedness may suggest the difficulty the patient may have verbalizing dissatisfaction with nursing care which (s)he must rely upon in the future. The positively skewed attitude toward nurses was consistent with other studies of attitudes toward nurses and other health professionals (Hulka et al., 1970, 1971; Korsch et al., 1968; Lewis et al., 1967; Sussman et al. 1967). A partial explanation of

positive skewing may be found in the questionnaire instructions directing respondents to think of "their nurses," a personal referent. Attitudes toward "physicians in general" and toward the respondent's own "personal physician" were reported to differ (Hulka et al., 1971).

High correlation coefficients obtained between subscales indicated a significant common factor between all subscales. Except in one case, each subscale possessed a reliability coefficient greater than its correlation coefficient with another subscale. The one exception involved the technical-professional area correlating with the trusting relationship in Trial 1 ($r = .637$). All other data showed some distinctness of clusters, and thus some evidence of discriminate validity (Risser, 1975).

The technical-professional content domain evidenced the least reliability (Cronbach's reliability coefficient was .637, N=60). This level was acceptable, but approached neither the desirable level of at least .800 nor the reliability coefficients attained by the other two subscales (Edwards, 1970). Both variability of respondent scores as measured by standard deviation of mean scores and scale homogeneity were less in the technical-professional area than in other subscales within the total scale. Risser (1975) questioned whether the technical-professional cluster represents a more diverse universe of items, with lower inter-item correlations. She suggested clearer definition and further refinement of the subscale may be indicated in further research.

Risser (1975) suggested that the large number of items selected from a variety of sources, especially from patient comments of their likes and dislikes of nursing, the review of items by nurses, and the literature review should ensure some degree of content validity.

Although construct validity was not established, the positive skewing of scores, expected from results of other satisfaction studies provided some evidence of construct validity.

Ventura, Fox, Corley and Mercurio (1982) used Risser's Patient Satisfaction questionnaire to evaluate the effectiveness of implementing the concepts of primary nursing. The mean subscale and total scores obtained for all patients were comparable to those reported by Risser (1975). Each subscale had an acceptable alpha coefficient, showing that items tended to behave consistently. The average inter-item correlations (indications of measurement domain homogeneity) for each subscale were also high, and both the estimates of reliability and homogeneity were comparable to those reported by Risser (1975). The subscale intercorrelations were high, approaching or exceeding the respective scale reliabilities.

Ventura et al. (1982) found the discriminant validity for the subscales to be doubtful as they appeared to measure one general dimension. The alpha coefficient for total scores was very high (.90). Ventura et al. (1982) suggested that it may not be possible to differentiate empirically among the hypothesized dimensions of patient satisfaction with nursing care. They further suggested that a general scale ignoring these subdimensions would have excellent reliability.

Using a process termed precision by replication, Hinshaw and Atwood (1982) further developed the Risser' Patient Satisfaction questionnaire. Precision by replication is defined as the stability of psychometric estimates for instrument reliability and validity over multiple studies (Hinshaw et al., 1982). They further state that this technique is important when instrument testing occurs within the context of field

research projects, since these projects may involve conditions that limit instrument-testing alternatives and interpretation; that is, small sample sizes and decreased control over numerous field conditions. The method they proposed for estimating the psychometric properties of Risser's Patient Satisfaction questionnaire was to analyze the stability of the coefficients over multiple testings with successive samples of modest size. They hypothesized that the instrument could be considered stable if the Cronbach's alpha coefficient (1951) did not vary by more than .10 to .20 across field studies.

The precision by replication method was demonstrated over a series of five clinical and administrative studies during a period of eight years, with a total of 600 patients, primarily medical-surgical inpatients and outpatients (Hinshaw et al., 1982). The Risser (1975) instrument was revised to measure patient satisfaction with inpatient nurses and nursing care. The basic conceptual framework and structure of the instrument were not changed. Hinshaw et al. (1982) conceptualized patient satisfaction as an outcome evaluation criterion of the patient's opinion of the care received from nursing staff.

Of the original four subscales constructed by Risser (1975) the instrument was reconceptualized to reflect the following three aspects of patient satisfaction with nurses and nursing care (Hinshaw et al., 1982: 171):

> Technical-professional factors - technical activities and the knowledge base required to competently complete the nursing care tasks.
>
> Trusting relationship - nursing characteristics that allow for constructive and comfortable patient-nurse interaction and communication aspects of the interaction.

Education relationship - nurses' ability to provide information for patients including answering questions, explaining care, and demonstrating techniques.

Only one item was revised for use with inpatient hospital subjects. In the item "The nurse gives good advice over the telephone," the phrase "over the telephone" was deleted (Risser, 1975: 49).

The two questions Hinshaw et al. (1982) raised were (1) Is each of the three subscales internally consistent?, and (2) Are the internal consistency estimates stable? They found that internal consistency estimates were satisfactory and stable across the various studies; for example, alpha-coefficients for the technical-professional subscale averaged .79, education coefficients averaged .78, and trust coefficients averaged .88. Inter-item, item-subscale, and inter-scale correlations collaborated the alpha coefficients.

Validity estimates for the Patient Satisfaction questionnaire were obtained in three of the five studies using construct validity methods (Hinshaw et al., 1982). Three construct validity techniques were used: convergent and discriminant strategy, discriminance, and predictive modelling. Empirical correlations moderately substantiated the multiple convergent/discriminant predictions. Discriminance was strongly documented for all but the education subscale, which had modest support. Predictive modelling produced moderate to strong validity estimates (Hinshaw and Atwood, 1982). Overall, Hinshaw et al. (1982) suggest that the Patient Satisfaction questionnaire has acceptable levels of validity and reliability.

Critical Incident Technique

The critical incident technique has been used in a variety of situations. Flanagan's (1954: 327) discussion remains the most useful description of the methodology and provides the following definitions:

> The Critical Incident Technique consists of a set of procedures for collecting direct observations of human behavior in such a way as to facilitate their potential usefulness in solving practical problems and developing broad psychological principles. The critical incident technique outlines procedures for collecting observed incidents having specific significance and meeting systematically defined criteria.
>
> An incident is any observable human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the person performing the act.
>
> A critical incident must occur in a situation where the purpose or intent of the act seems fairly clear to the observer and where its consequences are sufficiently definite to leave little doubt concerning the effect.

Flanagan and Schmid (1959) identify conditions which define a series of critical incidents and which are intended to obtain a representative objective set of factual events all judged by the observer to contribute to a single aim or conclusion. They are:

The definition of the situation observed. This usually includes the delimitation of incidents submitted to those involving specific persons, locations, conditions and activities.

The relevance of the stated aim or conclusion. This represents a judgment or inference on the part of the observer. Because of the explicitness of the definitions and the established criteria as to what constitutes an incident which has sufficient relevance and effect that it should be admitted as one piece of evidence regarding the stated aim or conclusion, these judgments and inferences are usually found to be relatively objective.

The qualifications of the observers. In order to make the types of judgment and inferences mentioned above, it is essential that observers have appropriate experience and training.

When these conditions are met, a sample of critical incidents can be treated like any other set of data to describe, to define, to compare, or to evaluate specific hypotheses (Flanagan and Schmid, 1959).

Flanagan (1954) recommends that the aim of the activity be described precisely. Since it is well known that extreme incidents can be more accurately remembered than behavior which is more nearly average in character, a practical means of obtaining the specific data is to obtain records of critical incidents. On the whole, it is preferable that the behavior or results observed are evaluated, classified, and recorded while the facts are still fresh in the mind of the observer. However, the technique can also be used for retrospective observations which are reported from memory. Evidence regarding the accuracy of reporting is usually contained in the incidents themselves. If full and complete details are given it can be assumed that the information is accurate, whereas vague reports suggest that the incident is not well remembered and that some of the data may be incorrect.

This raises the interesting question of whether or not patients are qualified to be observers of nursing and nursing care. Patient and staff perceptions of care quality have been found to differ considerably (Hefferin, 1979; Houston and Pasanen, 1972). While some of this difference is attributable to differences in the criteria which patients and professionals use for assessment, valid questions may also be raised about the extent to which consumers are competent to judge certain aspects of care. It is entirely possible that patients' lack of

technical knowledge may result in incorrect qualitative judgments. Tagliacozzo and Mauksch (1979) report that patients often feel helpless in evaluating the knowlege, skill and competence of care givers and, even when they are certain of their judgments, may be reluctant to express them. For this reason, patients' qualitative judgments tend to focus on the personality and demeanor of the care giver. Tessler et al. (1975) go a step further in suggesting that qualitative judgments are avoided when one is dependent, it is uncomfortable to accept that one's care may be less than adequate.

However, it is well recognized that the expectations which patients have of hospitals and health professionals form the context within which satisfaction and dissatisfaction must be assessed. Patients enter the health care system with a variety of characteristics, attitudes, and prior experiences. These, coupled with the knowledge and information they receive from health professionals, enable them to define their situation and to delineate what they perceive to be their own needs for care. Thus is formed a set of expectations about care outcomes, care giver behaviors, and the performance of the system. These expectations, which may be subject to considerable change during the course of the illness and treatment, form the standard against which care actually received is judged to be satisfactory or not satisfactory (Oberst, 1984).

Summary

Quality is of concern to both the providers and recipients of that care although neither understands its dimensions entirely. Quality assessment especially as it relates to the process and outcome of care

is of particular interest for those studying patient satisfaction. Satisfaction is believed to be a result of the expectations of care being met or exceeded. However, it is not yet clear if dissatisfaction and satisfaction of patient care are at opposite ends of the same continuum. Although patient satisfaction theory is not yet proven and instrument reliability and validity is often questionable, it is never the less considered by health care providers to be a patient's right to make comments regarding the care received. The validity of such comments may be scrutinized by health care providers in order to make improvements or maintain the status quo of care and services provided.

Of the four essential rights that Canadians have in health care, several legal and ethical considerations have been firmly entrenched in professional associations' code of ethics as well as in the social and legislative systems. Quality studies of patient care often provide a measure of an overall level of satisfaction. Although important in itself it is also important to capture patients' specific insights into the care delivery system. These insights, whether positive or negative, reflect upon the future relationship that the patient will have with the same and/or other health care providers and health care institutions. For these reasons both an overall and specific approach to getting patients' comments about the care they received will add to the usefulness of assessing the quality of care provided.

CHAPTER THREE

RESEARCH METHODOLOGY

This chapter contains a description of the research methodology employed for this study. The chapter is divided into four sections. Section one describes the study setting and subjects, and section two discusses the construction and validation of the instruments used. The third section deals with the data collection procedure and the last section describes the analysis of the data.

Study Setting and Subjects

The study was carried out in a large tertiary care hospital in Edmonton, Alberta. The hospital has allocated over 300 beds for adult surgery and over 200 beds for adult medicine. Table 1 presents a summary of reports drawn from the hospital comparing activity levels for medical and surgical patients. The reported activity levels were used to assist the development of criteria for selecting subjects

The subjects included in the study were acutely ill adults who experienced a medical and/or surgical intervention while being a patient. Other selection criteria required the subjects to: (1) be English literate; (2) reside within a 25 mile radius of the City of Edmonton; (3) be accessible by telephone for 14 days following discharge from the hospital; (4) be discharged from the hospital during the hours 0700 to 1600 on Monday through Friday; (5) be mentally competent;

(6) be the age of consent; (7) have been in hospital more than 2 days and less than 14 days; and (8) be willing to cooperate, and sign a consent for inclusion in the study.

Table 1

Level of Service Reported by Study Hospital for Adult Medical and Surgical Patients by Month and Year to Date (June, 1984)

Description	Month	Year to Date
Patients Admitted (Adult and Children*)	3,403	10,301
Occupancy Level		
Surgery	92%	92%
Medicine	97%	97%
Average Length of Stay (Days)		
Surgery	8.7	8.8
Medicine	12.5	12.5
Patients Admitted by Emergency (Adult and Children*)	1,213	3,564
Average Number of Patients Discharged Daily		
Surgery	37	**
Medicine	18	

* Information unavailable for adults only.

** Information not available.

Instrumentation

Two instruments, a questionnaire and a critical incidents interview guide, were utilized to collect data for this study. Questionnaires are comparatively less expensive and less time consuming than other research methods. Since the researcher was not present during the completion of the questionnaire, it was hoped researcher bias would be reduced. As the questionnaire offers the best opportunity for anonymity it is believed that the information is more likely to be accurate.

The critical incidents interview guide used an interview approach. Personal interviews increase the likelihood of establishing rapport with the respondents. The ability to develop greater rapport facilitates responses to sensitive questions -- those that may be potentially embarassing or threatening. The researcher is better able to get full, detailed answers through clarification and probing the sentiments that may underlie an expressed perception regarding care.

The telephone interview is an advantageous approach for respondent follow-up when considering its low cost and rapid completion with a relatively high response rate. Little difference in the quality of responses to telephone and personal interviews add to the validity of this approach.

Combining the questionnaire and interview approaches is successful in obtaining a high response rate while allowing the respondent privacy in filling out the questionnaires. The researcher was available for help, if desired. However, the researcher did not intervene unless asked once detailed instructions and examples on how to fill out the questionnaire were given. Feelings of privacy, confidentiality, and

anonymity are further ensured by allowing the respondent to seal the answers in an unmarked envelope.

Development of the Research Guide

The development of the research guide for the purpose of collecting data was generated from ideas obtained from the health care, nursing and psychology literature. The literature and discussions with colleagues helped clarify the approach to utilize in constructing the research guide.

The research guide was composed of five sections:

I. Personal Data Profile

II. Patient's Opinion of Nursing Care (questionnaire)

III. Critical Incidents Report (interview guide)

IV. Patient's Opinion of Nursing Care (questionnaire)

V. Critical Incidents Report (interview guide)

Sections I, II, and III were to be completed prior to discharge and Sections IV and V upon follow-up.

Section I of the research guide, designed for the purpose of collecting personal data, was developed by reviewing the hypotheses and purposes for the study as posed by the researcher. All personal data, except age, utilized fixed-alternative responses and were categorized prior to distribution for ease of data analysis. This section was to be completed by the researcher from questions posed to the subject.

Section II and Section IV of the research guide utilized the questionnaire entitled "Patient's Opinion of Nursing Care" developed by Risser (1975) and adapted by Hinshaw and Atwood (1982). The questionnaire was utilized in its original form. Based upon previous

research describing patient satisfaction questionnaires, it demonstrated the best documented validity and reliability data for measuring nursing care.

Section III and Section V, the critical incidents report, was designed by the researcher to gather data regarding: (1) those particularly positive or negative incidents which the subjects perceived as having a significant impact upon their perceptions of the care which nurses provided, (2) those behavioral factors which influenced the reporting of the respondent's opinions/perceptions, and (3) the direct description of the respondent's level of satisfaction or dissatisfaction with the nursing care received.

In reviewing the published literature, a critical incident approach to studying patient satisfaction could not be located. To develop a structure to assist in categorizing patient's reported critical incidents the researcher posed the question: what functions or roles do nurses carry out which would be perceived by patients as beneficial to or detracting from their ability to regain a feeling of wellness? To answer this question, published nursing and psychological theories were reviewed.

The theory which appeared to provide a good measure of identifiable nursing functions was that advanced by Henderson (1966). She (1966: 15) stated:

> The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible.

Henderson (1966) further identified fourteen functions that the nurse does to help the patient achieve independence. These functions are in relation to the patient's need for (1) breathing, (2) eating and drinking, (3) elimination, (4) movement and posture, (5) sleep and rest, (6) clothing, (7) maintenance of body temperature, (8) cleaning and grooming of the body and integumentary protection, (9) avoiding environmental dangers and injury to others, (10) communication, (11) worship, (12) work, (13) play and participation in recreation, and (14) learning and discovery.

The human need theory that supports Henderson's concept of nursing is Maslow's (1954) hierarchy of needs. This hierarchy includes (1) physiological needs, (2) safety needs, (3) belongingness and love needs, (4) need for self-esteem, and (5) need for self-actualization. Maslow considered man's responses to his needs as integrated behavioral units by emphasizing the relationships between the various needs. He believed that man functions holistically and seeks gratification of the most critical need for survival first, then afterwards he seeks to meet needs that are less critical (Maslow, 1966).

In relating Henderson's components of nursing care to Maslow's theory, it is clear that much of Henderson's focus is on the physiological and safety needs, with less emphasis on the other areas of needs. Of the fourteen components a majority of them relate to the physiological and safety needs. Maslow's psychosocial elements such as social esteem and self-actualization could be matched to Henderson's components that refer to communication of emotions, worship, work accomplishment, recreation, and learning to satisfy curiosity with

respect to normal development, health, and use of health facilities (Furukawa and Howe, 1980). The similarities between the two theories can be seen in Table 2.

Based upon the preceding discussion, five dimensions of care were defined to be used to guide categorization of positive and negative impact critical incidents reported by patients. The dimensions and definitions stated from the patient's perspective are:

Safety measures. Those activities which patients perceive nurses do to ensure their physical safety.

Therapeutic interventions. Those activities which patients perceive nurses do to aid their physical support or comfort. Such activities may be initiated by the nurse or secondary to a physician's order.

Psychosocial support measures. Those activities which patients perceive nurses do to promote their psychological and/or social recovery from or adjustment to the illness episode. Such activities may be directed toward the individual, family member or significant other.

Patient teaching. Those activities which patients perceive nurses do to assist their understanding of the symptoms and interventions experienced during the illness episode, as a result of or following the illness episode.

Hospital routines and environment. Those activities which patients perceive nurses do, but are actually beyond the nurses's direct sphere of influence. Such activities could be outlined by institutional policies and regulations or health care standards.

Table 2

Comparison of Maslow's Hierarcy
and Henderson's Framework

Maslow	Henderson
1. Physiological needs	1. Breath normally. 2. Eat and drink adequately. 3. Eliminate by all avenues of elimination. 4. Move and maintain desirable posture. 5. Sleep and rest. 6. Select suitable clothing. 7. Maintain body temperature. 8. Keep body clean and well groomed and protect the integument.
2. Safety needs	9. Avoid environmental dangers and avoid injuring others.
3. Belonging and love needs	10. Communicate with others. 11. Worship according to faith
4. Esteem needs	12. Work at something providing a sense of accomplishment. 13. Play or participate in various forms of recreation. 14. Learn, discover, or satisfy curiosity.
5. Self-actualization needs	

The wording of the items to elicit the patient's description of the critical incident were free-answer. Free-answer items were utilized in order to obtain fully descriptive responses to perceptions about potentially sensitive situations.

The observers in this study were the patients themselves. Patients have the opportunity to observe nurses and nursing care over the length of their hospital stay and are therefore in an excellent position to identify usual and unusual events or extremes of behavior (Flanagan, 1954). Since the study was done retrospectively, observers were not aware that a review of their perceptions regarding nurses and nursing care would take place. It can be safely assumed that no extraordinary nursing care was provided as nurses were not aware of the study occurring. It can also be assumed that patients were not taking particular note of care provided so as to report it to the researcher.

The items which identified the reporting of the critical incident was a fixed-alternative type -- either the patient reported it or (s)he did not report it. The method of reporting incidents also used a fixed-alternative type item. This type of response was most appropriate as the range of alternatives was known to the researcher, both through personal experience as well as the experience of colleagues.

Behavioral factors influencing the non-reporting of incidents have been discussed extensively in the literature, although these behaviors are often surmised and not directly studied. Any system or approach to ordering behaviors according to some classification is flawed in its ability to describe man's behavior truly. Man is a thinking, feeling, acting, social being who responds as a total organism to stimuli from his environment. In some instances, the components of man's behavior

respond in harmony, while at other times there is disunity among the components, with one or more predominating at any one time. As indepth analysis of "why" non-reporting occurs was not being attempted in this study, a simple method for categorization of rationales for non-reporting behavior was sought. Bloom's (1956) taxonomy for educational objectives appeared to be a useful method for categorizing and defining the rationale provided by the patients for not reporting their perceptions of the care received from nurses. The categories and definitions of each are:

Cognitive. Those statements which reflect knowledge, comprehension, intellectual abilities and skills.

Affective. Those statements which reflect internal values, interests and attitudes, which guide or control the making of choices for action.

Psychomotor. Those statements which reflect neuromuscular coordination and muscular action.

Other. Those statements which reflect external condition beyond the individual's sphere of influence.

The wording of the items to elicit the patient's rationale for not reporting the critical incident were free-answer. Free-answer items were utilized in order to obtain fully descriptive responses about potentially sensitive situations.

To directly describe the respondent's level of satisfaction or dissatisfaction with the nursing care received, two fixed-alternative type items were asked. These items asked the respondent if (s)he was satisfied or dissatisfied and to what degree.

The sequencing of the Critical Incidents Interview Guide items was designed to provide the best possible psychological flow from the standpoint of the respondents. Emphasis placed on the items was balanced to reduce content bias. The items were worded simply, maintaining a clear meaning with alternative wording available for clarification. Figure 1 outlines the sequence for completing Section III and Section V items and demonstrates the balancing of the items.

Validation of the Research Guide

Validity and reliability measures as reported in the literature (Risser, 1975; Hinshaw et al., 1982; Ventura et al., 1982) were considered adequate for the use of the questionnaire.

In order to establish content and face validity of the critical incident interview guide, it was distributed to six individuals with nursing backgrounds. These individuals were requested to review the interview guide for clarity, format and content. Three of the reviewers were nursing administrators and familiar with questionnaire design. The other three reviewers were nurse educators and had frequent contact with patients in hospital settings. All reviewers made written comments regarding their reaction to the content, appropriateness of item wording, item sequencing, and length of time for completion.

The critical incident report was perused by Dr. A. G. Konrad, the researcher's thesis advisor in the Department of Educational Administration, University of Alberta. In addition, Miss D. L. Smith, the researcher's thesis committee member and Director of Nursing of the University of Alberta Hospitals in Edmonton, Alberta reviewed the critical incident report and offered written comments regarding clarity,

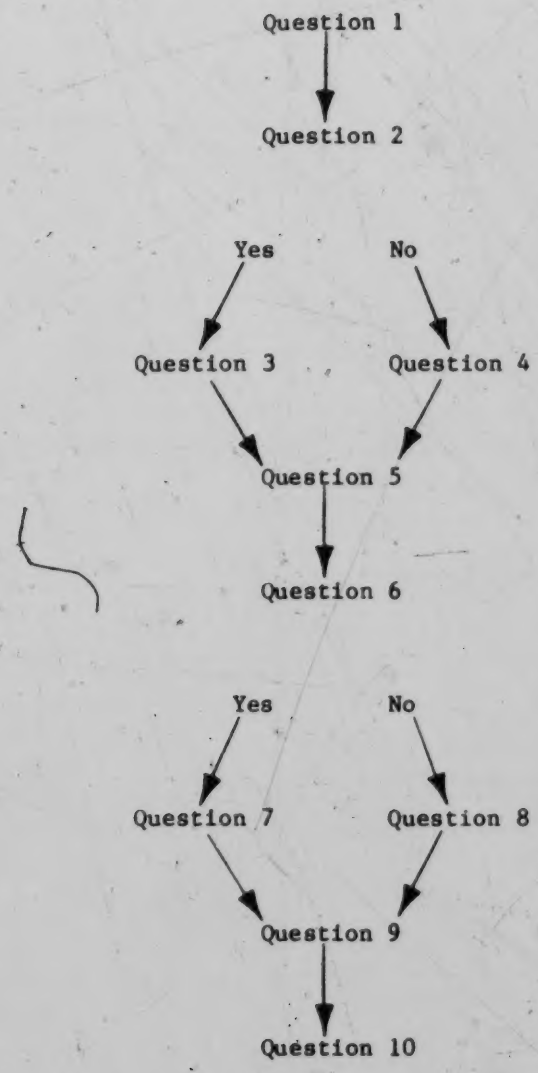

Figure 1

Sequence for Completing Critical Incidents Interview Guide

format and content. Miss Smith had previously conducted research using the critical incident technique (1980).

Responses received from the reviewers resulted in minor revisions of the report. The items were generally considered to be appropriate with logical sequencing and some minor modifications were made to item wording to improve clarity. After making the necessary changes a final draft of the critical incident report was constructed.

Some further (although limited) validity to the critical incident report is provided in the literature about patient satisfaction. Tremlett (1975) found that even if the patient knew how to make their suggestions, comments or criticisms known, they often did not communicate these views. Further it was found these views were/were not communicated according to certain criteria particular to the individual. Seventy-five percent of the reasons for non-communication were related to personality traits such as timidity, apathy, and embarrassment among others. Other factors implicated in patients communicating their views related to sociodemographic factors and the prospect of a further hospital stay.

The Instrument

A copy of the final form of the research guide is included in Appendix A. The guide is composed of five sections:

I Personal Data Profile

II Patient's Opinion of Nursing Care (questionnaire)

III Critical Incidents Report (interview guide)

IV Patient's Opinion of Nursing Care (questionnaire)

V Critical Incidents Report (interview guide)

Section I, Personal Data Profile, contains the following nine variables: type of intervention, age, gender, marital status, type of employment, history of previous hospitalizations, admission status, highest level of education, and date of follow-up.

Section II and Section IV, Patient's Opinion of Nursing Care questionnaire, include items which measure three dimensions of patient satisfaction: (1) technical-professional care; (2) trusting relationship; and (3) patient education. Items numbered 12, 13, 15, 16, 18, 20, 25 measured technical-professional care, items numbered 1, 3, 4, 5, 6, 9, 10, 14, 19, 22, 23 measured the trusting relationship, while items numbered 2, 7, 8, 11, 17, 21, 24 measured patient education. Each item was rated on a Likert-type scale, as to the perceived opinion held by the respondent which best described the nurse(s) providing care. The following response key was utilized:

5 STRONGLY AGREE

4 AGREE

3 UNCERTAIN

2 DISAGREE

1 STRONGLY DISAGREE

Section III and Section V, the Critical Incidents Report, included items which describe two critical incidents experienced during the current hospitalization and the reporting behavior corresponding to each incident. Item 1 described a positive-effect incident and items 2 through 4 described the related reporting behavior. Item 5 described a negative-effect incident anad items 6 through 8 described the related reporting behavior. Items 9 and 10 identify the respondents' perceived level and intensity of satisfaction with the nursing care received.

Pilot of the Instrument

In order to further establish content and face validity of the instrument, the critical incident report was utilized to interview four individuals who had recently been hospitalized. These individuals were requested to complete the interview basing their responses on their recent hospitalization experience.

The length of time required for completion varied from 10 to 15 minutes. All respondents voiced agreement that the meaning of each item was clear and the sequencing of the items logical.

Research Procedures

The research procedures, including the pre-implementation process, data collection procedures and data collection returns, are outlined.

Research approval and pre-implementation process

Prior to beginning the research study, permission was sought from the Clinical Investigations Committee of the selected hospital. In September 1984, letters were submitted to the committee by the researcher and the researcher's thesis advisor, requesting review and approval of the research proposal. Permission was granted to meet with the Clinical Investigation Committee to explain the study.

The meeting with the Clinical Investigation Committee took place October 1984. The nature of the study was explained and assurance given regarding confidentiality of the information. Questions raised were answered. Approval from the committee was received with the proviso that the Consent Form be modified such that the patient would not be sent a summary of the results of the study. (Correspondence is included in Appendix B.)

During October 1984, meetings with the supervisors and clerks of the medical and surgical nursing units of the hospital took place. At each meeting the nature of the study was explained. A laminated instruction card was distributed to each clerk explaining which patients were candidates for participating in the study and how to contact the researcher. Specifically, the clerks were instructed to contact the researcher about any patient being discharged during the research period who:

(1) was 18 years of age and over;

(2) spoke English;

(3) had been in hospital more than 2 days and less than 14 days.

Piloting the Data Collection Process

To determine the total amount of time that would be required for each subject contacted, a pilot with four subjects was carried out. On that date, two subjects completed the pilot review. The other two subjects did not meet the research study criteria.

The total amount of time required to complete the data collection process with each eligible subject averaged 48.5 minutes, and 10.5 minutes to eliminate those individuals not eligible. It was then estimated that the follow up telephone interview would require an average of 20 minutes to complete.

As Table 3 outlines, a total of 53 subjects was actually included in the study by the end of four weeks. The study sample was considered large enough so further sampling was discontinued. The subjects were randomly assigned to Group I or Group II for follow up. Data collection was completed in a six week period.

Table 3

Data Collection Workplan

Day of Sampling	Number of Patients Sampled per day					
	MTWTF	MTWTF	MTWTF	MTWTF	MTWTF	MTWTF
Day 0 Discharge	02325	45252	10424	24132		
Day 7 Group I		00203	23121	10212	12021	
Day 14 Group II			00323	22130	00212	12111

Data Collection Procedures

Following notification of a pending discharge, the researcher went to the nursing unit where the patient was located to determine if the patient was eligible to be included in the study and if so, to solicit his/her cooperation.

To determine eligibility for inclusion in the study, the patient's hospital record was reviewed and the researcher spoke with the patient. The hospital record was reviewed to determine: (1) length of hospitalization; (2) type of intervention; (3) place of residence; (4) degree of illness at admission; and (5) age. Discussion with the patient was to ensure: (1) English literacy; (2) telephone accessibility for 14 days following discharge from hospital; and (3) mental competence.

When the patient met all the study criteria, the purpose of the study including the time required to complete the study was further explained by the researcher. Each subject willing to cooperate was required to sign a consent indicating that they understood the research requirements. (The consent form is included in Appendix C.)

The patient was escorted to an interview room to complete Sections I, II, and III of the research guide. A personal interview was conducted with the subject to obtain the information for Section I, Personal Data. Detailed instructions and examples on how to fill out Section II were given verbally. The researcher answered any questions the subject had and then left the room to provide privacy while completing the questionnaire. The researcher returned to the interview room in 8 to 10 minutes.

Section III, the Critical Incidents Report, was completed next. Each interview was recorded on tape to be transcribed immediately after the interview was completed. Taping the interview assisted in maintaining a climate conducive to discussion, decreased the interview time, and increased the accuracy of transcribing the responses to each item.

The subjects were randomly assigned either to Group I for a seven day follow up, or to Group II for a fourteen day follow up. A questionnaire was given to each subject with a request to complete and return the questionnaire on a specified date in the self-addressed, stamped envelope provided. Following instructions about completing the questionnaire and arranging for the follow up telephone interview the subject was returned to the nursing unit. The subject was thanked for

his/her assistance and reminded to complete and return the questionnaire, as requested.

The day prior to the follow up date the subject was contacted by telephone and reminded to complete and return the questionnaire if they had not already done so. The subject was requested to state a convenient time for the researcher to telephone on the following day to complete the follow up interview.

The follow up interview was conducted on the specified day with a recording device operating during the interview. The interview was terminated by thanking the subject for his/her cooperation during the study and again reminded to return the completed questionnaire if not already done. The tape was transcribed immediately following the interview.

Data collection returns

Fifty-three subjects were included in the study for which a total of fifty-three questionnaires and interviews were completed by November 2, 1984. All returns were usable.

A total of forty-nine questionnaires or 92.5 percent were returned by November 30, 1984. All returns were usable. Table 4 summarizes information related to the distribution and return of questionnaires (section IV of research guide).

A total of fifty-two scheduled interviews or 98.1 percent were completed by November 16, 1984. Table 5 summarizes information related to the scheduled and completed interviews (Section V of research guide). One study subject was unable to complete the study requirements due to rehospitalization.

Table 4

Distribution and Return of Research Guide
(Section IV)

Time of Follow Up	Questionnaires Distribution	Return N	Return %
7 days	26	23	88.5
14 days	27	26	96.3
Total	53	49	92.5

Table 5

Distribution and Return of Research Guide
(Section V)

Time of Follow Up	Interviews Scheduled	Completions N	Completions %
7 days	26	25	96.1
14 days	27	27	100
Total	53	52	98.1

Data Analysis

The survey instruments were constructed to facilitate key punching of the raw data which could then be transferred directly to computer cards. The response key for questionnaire items 1, 2, 5, 8, 10, 11, 13, 19, 20, 22, and interview item 10, were reversed to be reflective of the scale where 5 was rated to be very satisfied and 1 was rated to be very dissatisfied. The ages of the subjects were reviewed and categorized into four groups of approximately the same frequency for statistical comparison. Also, for statistical comparison the marital status was

recategorized to be (1) married and (2) other. All subjects, except one, were non-health care workers and therefore no statistical analysis was completed on this variable.

The following statistical analyses were utilized in this study.

1. Frequency and percentage distribution was used to describe the personal data of all respondents.

2. Frequency and percentage distribution was used to describe the personal data of respondents who experienced a medical intervention.

3. Frequency and percentage distribution was used to describe the personal data of respondents who experienced a surgical intervention.

4. Ranking of items by means was used to identify those aspects of care within the technical-professional, trusting, and educational dimensions perceived as satisfying prior to discharge, 7 days, and 14 days following discharge.

5. Free-answer responses for the critical incidents and reporting behaviors were categorized and then frequency and percentage distribution was applied.

6. Frequency and percentage distribution was used to describe fixed-alternative responses for reporting incidents.

7. Differences of opinions of respondents regarding satisfaction with technical-professional care, the trusting relationship, and patient education, on the basis of age were examined by one-way analysis of variance procedures.

8. Differences of opinions of respondents regarding satisfaction with technical-professional care, the trusting relationship and patient education on the basis of gender were examined by t-test.

9. Differences of opinions of respondents regarding satisfaction with technical-professional care, the trusting relationship and patient education on the basis of marital status were examined by t-test.

10. Differences of opinions of respondents regarding satisfaction with technical-professional care, the trusting relationship and patient education on the basis of previous hospitalization were examined by one-way analysis of variance procedures.

11. Differences of opinions of respondents regarding satisfaction with technical-professional care, the trusting relationship and patient education on the basis of admission status were examined by t-test.

12. Differences of opinions of respondents regarding satisfaction with technical-professional care, the trusting relationship and patient education on the basis of highest level of education attained were examined by one-way analysis of variance procedures.

13. Differences of opinions of respondents regarding satisfaction with technical-professional care, the trusting relationship, and patient education, on the basis of type of intervention were examined by t-test.

14. Differences of opinions of respondents prior to discharge regarding satisfaction with technical-professional care, the trusting relationship and patient education on the basis of Group I or Group II assignment were examined by t-test.

15. Differences of opinions of respondents following discharge regarding satisfaction with technical-professional care, the trusting relationship and patient education on the basis of Group I or Group II assignment were examined by t-test.

16. Differences of opinions of Group I respondents regarding satisfaction with technical-professional care, the trusting relationship and patient education, initially and at the time of follow up were examined by correlated t-tests.

17. Differences of opinions of Group II respondents regarding satisfaction with technical-professional care, the trusting relationship and patient education, initially and at the time of follow up were examined by correlated t-tests.

Summary

The subjects included in this study were acutely ill, hospitalized adults who experienced a medical and/or surgical intervention while being a patient. Data regarding hypothesized sociodemographic variables were obtained.

The research guide included a self-administered questionnaire and critical incident interview approach for the collection of data. Questions concerning three dimensions of patient satisfaction: technical-professional care; trusting relationships; and patient education, were included in the questionnaire. The interview included items which describe a positive effect incident and a negative- effect incident, the associated reporting behaviors and a direct statement regarding perceived intensity of satisfaction/dissatisfaction with nursing care received.

Data were collected twice from each patient. Initial data collection occurred prior to discharge from the hospital, and then again either seven days or fourteen days following discharge from the hospital.

Data were analyzed to provide frequency distributions, means, one-way analysis of variance, _t_ tests, and correlated _t_ tests.

CHAPTER FOUR

DESCRIPTIVE RESEARCH FINDINGS

This chapter contains the descriptive research findings of the study. The initial section, dealing with the personal data, provides profiles of the respondents. The second section discusses the respondent's opinions of the technical-professional care, trusting relationship, and patient education dimensions of nursing care. Changes in the expressed levels of satisfaction with these dimensions over time are presented. The third section relates positive and negative events experienced by the respondents and perceived as critical. The final section presents a summary of the chapter.

Personal Data Profiles

The patients were requested to respond to nine questions regarding personal data. Information concerning age, gender, marital status, employment as a health care worker, previous hospitalization, date of last hospitalization, admission status, level of education, and type of intervention was obtained.

All Respondents

Table 6 presents the frequency and percentage distribution that summarize the responses to the nine items.

Age. Of the 53 respondents in the study an equal number of respondents were between the ages of 18 and 29 and between 30 and 49.

These groups comprised 22.6 percent each of the total group. Therefore, slightly less than one-half (45.2%) of the respondents were 49 years of age or younger. The greatest percentage (28.3%) were in the age 50 to 59 years, with a slightly smaller percentage (26.4%) occurring in the 60 and over age group.

Gender. Table 6 indicates that 24 or 45.3 percent of the respondents were male. The remaining 29 respondents or 54.7 percent were female.

Marital status. The majority of the respondents (58.5%) indicated that they were married. In decreasing frequency, the other respondents were single (15.1%), widowed (11.3%), divorced (9.4%), and other (5.7%).

Employment as a health care worker. As shown in Table 6, the majority of the respondents (98.1%) were non-health care workers. One respondent, or 1.9 percent of the group had previously been employed in the health care field.

Previous hospitalization. The majority of the patients (96.2%) had been previously hospitalized. Two respondents or 3.8 percent had never been in hospital as a patient prior to the current hospitalization.

Date of last hospitalization. Table 6 shows that of the 51 respondents previously hospitalized, the majority (66.7%) or 34 respondents' hospitalizations had occurred within the previous 5 years, 1980 to 1984. Eleven respondents, or 21.6 percent had their last hospitalization from 6 to 10 years ago (1975 to 1979), and 11.8 percent had been hospitalized prior to 1975.

Table 6

Frequency and Percentage Distribution
of Personal Data of all Respondents

Data	Frequency	Percent*
Age		
60 and over	14	26.4
50- 59	15	28.3
30-49	12	22.6
18-29	12	22.6
Gender		
Male	24	45.3
Female	29	54.7
Marital Status		
Married	31	58.5
Single	8	15.1
Widowed	6	11.3
Divorced	5	9.4
Other	3	5.7
Employed as a Health Care Worker		
Yes	1	1.9
No	52	98.1
Previous Hospitalization		
Yes	51	96.2
No	2	3.8
Date of Last Hospitalization		
1980-1984	34	66.7
1975-1979	11	21.6
1974 and before	6	11.8

Table 6 (Continued)

Data	Frequency	Percent*
Admission Status		
Elective	24	45.3
Emergency	29	54.7
Level of Education		
Grade 1-9	15	28.3
Grade 10-12	23	43.4
Post-secondary	15	28.3
Type of Intervention		
Medical	24	45.3
Surgical	29	54.7
Time of Follow up		
7 Days	26	49.1
14 Days	27	50.9

* Where totals do not equal 100% error due to rounding.

Admission status. Twenty nine respondents or 54.7 percent were admitted to the hospital as requiring emergency care. The remainder of the respondents (45.3%) were electively admitted to the hospital.

Level of education. The largest number of respondents (43.4%) indicated Grade 10 to 12 was their highest level of education. An equal number of the respondents had Grade 1 to 9 or postsecondary education. These groups comprised 28.3 percent each of the total group.

Type of intervention. Twenty nine respondents or 54.7 percent received surgical interventions while hospitalized. The remainder of the respondents (45.3%) received medical interventions.

Time of follow-up. With random assignment to groups, slightly more than one-half (50.9%) of the respondents were followed up 14 days after discharge from hospital. The remaining 26 respondents or 49.1 percent were followed up 7 days after discharge.

Medical/Surgical Interventions

The personal data profiles were examined to further describe the medical and surgical respondents and clarify any difference which may be present.

Age. Table 7 indicates that of the 24 medical respondents in the study, 10 or 41.7 percent were 60 and over while 37.5 percent were between the ages of 50 and 59. The remaining 5 respondents were either between 30 and 39 (12.5%) or between 18 to 29 (8.3%) years of age.

In contrast, of the 29 surgical respondents in the study only 10 or 34.5 percent were in the 50 and over age groups. Specifically, 13.8 percent were 60 and over while 20.7 percent were between the ages of 50 to 59. The other 19 respondents were the majority, either being in the 30 to 49 (31.0%) or 18 to 29 (34.5%) age group. Therefore, the majority of medical respondents were older than the majority of the surgical respondents.

Gender. Table 7 indicates that an equal number of the medical respondents were male and female, while the greatest percentage (58.6%) of the surgical respondents were female and 41.4 percent were male.

Table 7

Frequency and Percentage Distribution of Personal Data of Medical/Surgical Respondents

Data	Medical Frequency	Medical Percent*	Surgical Frequency	Surgical Percent*
Age				
60 and over	10	41.7	4	13.8
50- 59	9	37.5	6	20.7
30-49	3	12.5	9	31.0
18-29	2	8.3	10	34.5
Gender				
Male	12	50.0	12	41.4
Female	12	50.0	17	58.6
Marital Status				
Married	14	58.3	17	58.6
Single	3	12.5	5	17.2
Widowed	3	12.5	3	10.3
Divorced	3	12.5	2	6.9
Other	1	4.2	2	6.9
Employed as a Health Care Worker				
Yes	0	0.0	1	3.6
No	24	100.00	28	96.4
Previous Hospitalization				
Yes	24	100.0	27	93.1
No	0	0.0	2	6.9
Date of Last Hospitalization				
1980-1984	19	79.2	15	55.6
1975-1979	5	20.8	6	22.2
1974 and before	0	0.0	6	22.2
Admission Status				
Elective	5	20.8	19	65.5
Emergency	19	79.2	10	34.5
Level of Education				
Grade 1-9	11	45.8	4	13.8
Grade 10-12	9	37.5	14	48.3
Postsecondary	4	16.7	11	37.9

* Where totals do not equal 100% error due to rounding.

Marital status. An equal number of the medical respondents were single, widowed, or divorced. These groups comprised 12.5 percent each of the total group. The greatest percentage (58.3%) were married, with the smallest percentage (4.2%) occurring in the other group.

The married status was the majority (58.6%) for the and surgical respondents. An equal number were divorced or other, with each comprising 6.9 percent of the total group. Seventeen percent were single respondents while 10.3 percent were widowed.

Employed as a health care worker. Table 7 indicates that there were no health care workers among the medical respondents. In addition, twenty eight or 96.4 percent of the surgical respondents were not health care workers. The one respondent who was a health care worker had been previously employed as a paramedic.

Date of last hospitalization. Table 7 shows that all medical respondents were hospitalized within the last ten years. The greatest percentage (79.2%) occurred during the years 1980 to 1984, and 20.8 percent during 1975 to 1979.

Of the surgical respondents who had been hospitalized previously, an equal number occurred during 1975 to 1979, and 1974 and before. These groups comprised 22.2 percent each of the total group. The greatest percentage (55.6%) of the surgical respondents were last hospitalized during 1980 to 1984.

Admission status. As shown in Table 7, 79.2 percent of the medical respondents were emergency admissions and 20.8 percent were elective

admissions. The majority (65.5%) of surgical admissions were elective while the other 34.5 percent were emergencies.

Level of education. The highest level of education attained by medical respondents was lower than that of the surgical respondents. The majority of medical respondents (45.8%) had Grade 1 to 9, 37.5 percent had Grade 10 to 12, while 16.7 percent had some postsecondary preparation. In contrast, the majority of surgical respondents (48.3%) had Grade 10 to 12, 37.9 percent had some postsecondary preparation, and 13.8 percent had only Grade 1 to 9 education.

Opinions of Nursing Care

Respondents were asked to indicate their opinion of the level of agreement with items describing three dimensions of nursing care: technical-professional care, trusting relationship, and patient education. All respondents' opinions were measured twice. The first measurement occurred prior to discharge from hospital, and then again at either 7 days or 14 days following discharge. Ranking of items by means was utilized to identify the satisfaction profiles of each dimension for each time of measurement. The means are reflective of the scale where:

5 = Very Satisfied
4 = Satisfied
3 = Uncertain
2 = Dissatisfied
1 = Very Dissatisfied

The first subsection discusses the satisfaction profile of all respondents which was measured prior to discharge from hospital. The second subsection discusses the satisfaction profile of the respondents' opinions measured at 7 days following discharge, and the last subsection deals with the profiles of opinions measured 14 days following discharge.

Perceptions Prior to Discharge

Technical-professional care. Table 8 contains the means and rank order of means showing the perceived level of satisfaction with items relating to the technical-professional care provided by the nurses. All items were ranked as being satisfying with means ranging from 4.21 to 3.81. Patients were satisfied with the technical-professional aspects of the care received from the nurses.

Trusting relationship. Table 9 summarizes the means and rank order of means showing the degree to which each item was perceived as satisfying to the relationship.

Six of the seven items were perceived as satisfying with means ranging from 4.34 to 3.72. For one item, the nurse is too busy at the desk to spend time talking to me, respondents were uncertain (3.42). It appears that the trusting relationship between patients and nurses are generally satisfying.

Patient education. The means and rank order of means showing the perceived level of satisfaction with each item of patient education are contained in Table 10. There were no items in the dimension of patient education ranked as being very satisfying. Six of the seven items were ranked as satisfying with means ranging from 3.98 to 3.56. Respondents were uncertain about one item. The item was: I wish the nurse would tell me more about the results of my test than he/she does (Mean = 2.93). It appears that patients perceived patient education to be satisfying. Apparently, patients were concerned that nurses do not tell them enough about the results of their tests.

Table 8

Mean and Rank Order of Means of Responses Prior to Discharge Satisfaction with the Technical-Professional Care

Item	Mean	Rank Order
The nurse is often too disorganized to appear calm.	4.21	1
The nurse is not precise in doing his/her work.	4.14	2
The nurse is skillful in assisting the doctor with procedures.	4.00	3
The nurse really knows what he/she is talking about.	3.89	4
The nurse makes it a point to show me how to carry out the doctor's orders.	3.84	5
The nurse gives good advice.	3.83	6
The nurse is too slow to do things for me.	3.81	7
Average of item means	3.96	

Table 9

Mean and Rank Order of Means of Responses Prior to Discharge Satisfaction with the Trusting Relationship

Item	Mean	Rank Order
A person feels free to ask the nurse questions.	4.34	1
The nurse is pleasent to around.	4.32	2
I'm tired of the nurse talking down to me.	4.20	3
The nurse is just not patient enough.	4.09	4
When I need to talk to someone, I can go to the nurse with my problems.	3.98	5
Just talking to the nurse makes me feel better.	3.96	6
The nurse is understanding in listening to a patient's problems.	3.93	7
The nurse is a person who can understand how I feel.	3.77	8
The nurse should be more attentive than he/she is	3.74	9
The nurse should be more friendly than he/she is.	3.72	10
The nurse is too busy at the desk to spend time talking to me.	3.42	11
Average of item means	3.95	

Table 10

Means and Rank Order of Means of Responses
Prior to Discharge Satisfaction
with Patient Education

Item	Mean	Rank Order
The nurse explains things in simple language.	3.98	1
Too often the nurse thinks you can't understand the medical explanation of your illness, so he/she just doesn't bother to explain.	3.91	2.5*
The nurse asks a lot of questions, but once he/she finds the answers, he/she doesn't seem to do anything.	3.91	2.5*
The nurse gives directions at just the right speed.	3.75	4
It is always easy to understand what the nurse is talking about.	3.70	5
The nurse always gives complete enough explanations of why tests are ordered.	3.56	6
I wish the nurse would tell me more about the results of my tests than he/she does.	2.93	7
Average of items means	3.68	

* Indicates tied ranks.

Perceptions Seven Days After Discharge

Technical-professional care. Table 11 presents the means and rank order of means showing the perceived level of satisfaction with items relating to technical-professional care. All items were ranked as being satisfying. It appears that 7 days following discharge from hospital patients were satisfied with the technical-professional care received from the nurses.

Table 11

Means and Rank Order of Means of Responses on Satisfaction with Technical-Professional Care Seven Days After Discharge

Item	Mean	Rank Order
The nurse is often too disorganized to apear calm.	4.09	1
The nurse is skillful in assisting the doctor with procedures.	4.00	2
The nurse gives good advice.	3.96	4*
The nurse is too slow to do things for me.	3.96	4*
The nurse is precise in doing his/her work.	3.96	4*
The nurse makes it a point to show me how to carry out the doctor's orders.	3.91	6
The nurse really knows what he/she is talking about.	3.83	7
Average of items means	3.96	

* Indicates tied ranks.

Trusting relationship. Table 12 contains the means and rank order of means summarizing the perceived level of satisfaction with the trusting relationship with nurses. All items ranked as being satisfying with means ranging from 4.17 to 3.61. The trusting relationship was perceived by patients as satisfying.

Patient education. The means and rank order of means showing the perceived levels of satisfaction with patient education is outlined in Table 13. Six of the seven items were satisfying, with means ranging from 3.96 to 3.64. For one item, I wish the nurse would tell me more about the results of my tests than he/she does, respondents were uncertain (3.18). Therefore, it appears that seven days after discharge patients perceive patient education to be moderately satisfying.

Perceptions Fourteen Days After Discharge

Technical-professional care. Table 14 contains the means and rank order of means showing the perceived level of satisfaction with items relating to the technical-professional care provided by nurses. All items were ranked as being satisfying with means ranging from 4.12 to 3.81. Patients were satisfied with the technical-professional care received from the nurses.

Trusting relationship. Table 15 summarizes the means and rank order of means showing the degree to which each item was perceived as satisfying to the relationship. Two items were ranked as uncertain. They were: the nurse is a person who can understand how I feel (Mean = 3.46); and the nurse is too busy at the desk to spend time talking with me (Mean = 3.23).

Table 12

Means and Rank Order of Means of Responses on Satisfaction with the Trusting Relationship Seven Days After Discharge

Item	Mean	Rank Order
The nurse is pleasant to be around.	4.17	1.5*
A person feels free to ask the nurse questions.	4.17	1.5*
The nurse is just not patient enough.	3.96	3.5*
I'm tired of the nurse talking down to me.	3.96	3.5*
Just talking to the nurse makes me feel better.	3.91	5
The nurse should be more friendly than he/she is.	3.87	6
The nurse should be more attentive than he/she is.	3.83	7
The nurse is understanding in listening to a patient's problems.	3.78	8
When I need to talk to someone, can go to the nurse with my problems.	3.73	9
The nurse is a person who can understand how I feel.	3.70	10
The nurse is too busy at the desk to spend time talking with me.	3.61	11
Average of items means	3.88	

* Indicates tied ranks.

Table 13

Means and Rank Order of Means of Responses on Satisfaction with Patient Education Seven Days After Discharge

Item	Mean	Rank Order
The nurse explains things in simple language.	3.96	1
Too often the nurse thinks you can't understand the medical explanation of your illness, so he/she just doesn't bother to explain.	3.87	2.5*
The nurse asks a lot of questions, but once he/she finds the answers, he/she doesn't seem to do anything.	3.87	2.5*
It is always easy to understand what the nurse is talking about.	3.78	4.5*
The nurse gives directions at just the right speed.	3.78	4.5*
The nurse always gives complete enough explanations of why tests are ordered.	3.64	6
I wish the nurse would tell me more about the results of my tests than he/she does.	3.18	7
Average of items means	3.73	

* Indicates tied ranks.

Table 14

Means and Rank Order of Means of Responses on Satisfaction with Technical-Professional Care Fourteen Days After Discharge

Item	Mean	Rank Order
The nurse is often too disorganized to appear calm.	4.12	1
The nurse is skillful in assisting the doctor with procedures.	4.04	2
The nurse is precise in doing his/her work.	3.96	3
The nurse gives good advice.	3.92	4
The nurse makes it a point to show me how to carry out the doctor's orders.	3.89	5.5*
The nurse really knows what he/she is talking about.	3.89	5.5*
The nurse is too slow to do things for me.	3.81	7
Average of items means	3.95	

* Indicates tied ranks.

The other nine items were perceived as satisfying with means ranging from 4.15 to 3.58. The trusting relationship between the patients and nurses were generally satisfying.

Patient education. The means and rank order of means showing the perceived level of satisfaction with items relating to patient education are contained in Table 16. Four items in the patient education dimension ranked as being satisfying, while three items were ranked as being uncertain. The three items ranked uncertain included: too often the nurse thinks you can't understand the medical explanation of your illness, so he/she just doesn't bother to explain (Mean = 3.46); the nurse always gives complete enough explanations of why tests are ordered (Mean = 3.31); and, I wish the nurse would tell me more about the results of my tests than he/she does (Mean = 3.04). Patients perceived themsleves to be only slightly satisfied with patient education.

Critical Incidents and Reporting Behaviors

Patients were asked to describe two situations that occurred during their hospitalization, one which they perceived to be beneficial or helpful, and the other, which they perceived to be detrimental or unpleasant. Information was obtained to determine whether or not the nurse was made aware of the patient's feelings regarding each stated incident. Patients then described how the nurse was made aware. In the case where the nurse was not made aware, the patient described why he/she did not make the nurse aware.

The critical incidents described were categorized by area of nursing practice activity. Reporting behaviors were classified into three behavioral domains.

Table 15

Means and Rank Order of Means of Responses on Satisfaction with the Trusting Relationship Fourteen Days After Discharge

Item	Mean	Rank Order
The nurse is pleasant to be around.	4.15	1
A person feels free to ask the nurse questions.	4.04	2
Just talking to the nurse makes me feel better.	3.96	3
The nurse is just not patient enough.	3.89	4
I'm tired of the nurse talking down to me.	3.88	5
The nurse is understanding in listening to a patient's problems.	3.85	6
The nurse should be more attentive than he/she is.	3.58	8*
The nurse should be more friendly than he/she is.	3.58	8*
When I need to talk to someone, can go to the nurse with my problems.	3.58	8*
The nurse is a person who can understand how I feel.	3.46	10
The nurse is too busy at the desk to spend time talking with me.	3.23	11
Average of items means	3.75	

* Indicates tied ranks.

Table 16

Means and Rank Order of Means of Responses on Satisfaction with Patient Education Fourteen Days After Discharge

Item	Mean	Rank Order
The nurse explains things in simple language.	3.96	1
The nurse asks a lot of questions, but once he/she finds the answers, he/she doesn't seem to do anything.	3.81	2
It is always easy to understand what the nurse is talking about.	3.65	3
The nurse gives directions at just the right speed.	3.58	4
Too often the nurse thinks you can't understand the medical explanation of your illness, so he/she just doesn't bother to explain.	3.46	5
The nurse always gives complete enough explanations of why tests are ordered.	3.31	6
I wish the nurse would tell me more about the results of my tests than he/she does.	3.04	7
Average of items means	3.54	

Positive-Effect Incidents

Table 17 presents the frequency and percentage distributions that summarize by category the positive-effect critical incident reported by patients prior to discharge. Two patients (3.8%) were unable to recall any particular incidents that they felt were worthy of reporting. Table 17 shows that the majority of the patients (41.5%) who responded reported critical incidents about psychosocial support measures, 15 or 28.3 percent reported patient teaching incidents, and 17.0 percent of the incidents were about therapeutic interventions. The two smallest groups, safety measures and hospital routines and environment, were 7.5 percent and 1.9 percent, respectively.

Table 17

Frequency and Percentage Distributions of Categories of Positive-Effect Incidents Reported Prior to Discharge

Category	Frequency	Percent*
Psychosocial Support Measures	22	41.5
Patient Teaching	15	28.3
Therapeutic Interventions	9	17.0
Safety Measures	4	7.5
No response	2	3.8
Hospital Routines and Environment	1	1.9

* Where totals do not equal 100% error due to rounding.

Patients described psychosocial support measures whereby the nurse was obliging, jovial, cordial, responsive, and kind and caring. The nurses were perceived to identify with the patients by reassuring fears and embarrassment, providing encouragement for recovery and talking with and actively listening to them.

Patient teaching activities described by patients primarily focused on thorough explanations regarding medication, procedures, and routines. Patients felt informed and that their questions were answered fully. Some patients stated that the nurses used pictures to aid their explanations, and other patients reported that their significant others were involved during the teaching.

Patients described situations relating to therapeutic interventions where the nurse provided assistance when the patient was unable, for example, with hygienic care and ambulation. Other descriptions portrayed nurses changing soiled linens and dressings, monitoring blood transfusions, and adjusting the bed to promote sleep.

Safety measures most frequently described by patients were in urgent situations where the nurse was perceived to respond promptly to a call for help. One patient described fear for his personal safety as the other patients in the room displayed confusion, agitation, and were constantly noisy. The nurse responded by explaining to the patient why he was not in danger and the patient then perceived his fear to be unnecessary. One patient stated that the nurse influenced the hospital routines and environment by arranging for day passes.

Table 18 summarizes the frequency and percentage distributions for reporting the positive-effect critical incidents. Thirty eight patients

(74.5%) stated that they made the nurses aware of their feelings and had done so by speaking with the nurses personally. The other thirteen patients, or 25.5 percent had not made the nurses aware of their feelings.

Table 18

Frequency and Percentage Distributions of Reporting the Positive-Effect Critical Incident

Category	Frequency	Percent
Nurse made aware	38	74.5
Nurse not made aware	13	25.5

Table 19 shows the frequency and percentage distribution for the classification of non-reporting behavior. One patient did not report any feelings for a psychomotor reason and another had no reason. Seven patients (53.8%) did not make the nurses aware for affective reasons, and four patients or 30.8 percent for other reasons which reflected external conditions. Non-reporting behaviors for the positive-incident were not due to cognitive reasons.

Affective domain rationales provided by patients for not making the nurses aware of their feelings were primarily because they felt that by being responsive and cooperative they were showing their appreciation. One patient stated that she had difficulty expressing feelings, while another patient assumed that the reported incident was a part of the nurse's job and, therefore, felt no need to express any feelings towards the nurse. One patient expressed great annoyance with the physician and hospital, and although none was felt towards the nurse he found himself

unable to express this to the nurse. Another patient was physically unable to make the nurse aware of his feelings about the stated incident as he was recovering from anaesthesia.

Table 19

Frequency and Percentage Distribution of Classifications of Non-Reporting Behavior

Classification	Frequency	Percent*
Affective	7	53.8
Other	4	30.8
Psychomotor	1	7.6
No reason	1	7.6
Cognitive	0	0

* Where totals do not equal 100% error due to rounding.

During the follow-up interviews patients described the same positive-effect incidents that they described initially. No further attempts had been made by the patients to make the nurses aware of their feelings. Furthermore, those patients who had not appraised the nurses of their feelings provided the same rationales for not doing so, as they had previously.

Negative-Effect Incidents

Table 20 presents the frequency and percentage distributions that summarize by category the negative-effect critical incidents reported by patients prior to discharge. The majority (43.4%) of the patients stated that they experienced no negative-effect incidents. Incidents in

the category, therapeutic interventions, accounted for 28.3 percent while psychosocial support measures accounted for 9.4 percent. An equal number of patients reported incidents in the safety measures and hospital routines and environment categories (7.5% each). The smallest group of incidents were 2 or 3.8 percent in the patient teaching category.

Table 20

Frequency and Percentage Distributions of Categories of Negative-Effect Incidents Reported Prior to Discharge

Category	Frequency	Percent*
No response	23	43.4
Therapeutic Interventions	15	28.3
Psychosocial Support Measures	5	9.4
Safety Measures	4	7.5
Hospital Routines and Environment	4	7.5
Patient Teaching	2	3.8

* Where totals do not equal 100% error due to rounding.

A variety of incidents were described relating to therapeutic interventions. Two patients depicted situations where the nurse refused a request felt to be appropriate by the patient -- providing a drink of water and trimming ingrown toe nails. One patient described a nurse as "pushy and intolerant" as the nurse had pressed the patient to walk beyond her physical endurance. One incident portrayed the nurse performing a procedure improperly and was perceived to result in a

slower recovery, and another where the nurse was perceived to lack the necessary knowledge and skills to care for a nasogastric tube and did not seek assistance from another nurse when needed. Patients related situations where the nurse was observed to rush causing a dressing to be "ripped off" by accident, too busy to monitor bedridden patients resulting in urine incontinence, or too busy to administer medication for pain relief when requested. Two patients expressed considerable anger that they were made to feel that they had to beg for pain relief and perceived the nurses to give analgesics grudgingly.

In the category, psychosocial support measures, patients described nurses as brusque, rude, cool, and unsmiling. Other situations portrayed nurses to have demonstrated annoyance and impatience.

Safety measures most frequently described as negative incidents occurred when the nurse was perceived to have responded slowly to a call for help, or when the call bell had been left out of reach and the patient had been unable to call the nurse for help. One patient described an incident where she had observed the nurse telling another patient to "shut up" and threatening to do "something else" to that patient. The patient reporting this incident appeared to be very upset by it.

Hospital routines and environment were described in four patient situations. One patient found it disturbing that the nursing staff walked through the patients' rooms at shift change, and felt that this was unnecessary. Another patient was incensed that the nurse had removed cigarettes from the patient's room without permission. The patient remained angry at the nurse even after the hospital's smoking policy was explained. Two patients were upset by the rooms they were

assigned to. One was particularly upset because the other patients in the room had seizures. The patient had never witnessed a seizure previously and felt that she shouldn't have been assigned to that room by the hospital, or at the very least, the nurses should have prepared her for what happened during a seizure.

Two patients expressed discontent with patient teaching. One stated that "unless you asked a lot of questions, the nurse didn't give you much detail," while the other said that no explanations were provided about "what would happen before the operation."

Table 21 summarizes the frequency and percentage distributions for reporting the negative-effect incidents. Seven patients (22.3%) had made the nurses aware of how they felt. Five of them had done so by speaking to the nurses personally, while the other two patients had spoken to the unit supervisor. The other 23 patients (76.7%) had not appraised the nurses of their feelings.

Table 21

Frequency and Percentage Distribution of Reporting the Negative-Effect Critical Incident

Reporting	Frequency	Percent
Nurse not made aware	23	76.7
Nurse made aware	7	23.3

Table 22 shows the frequency and percentage distributions for the classification of non-reporting behaviors. Two of the patients did not report their feelings for a psychomotor reason, and another two were unable to state a reason. Fourteen patients (60.9%) did not make the nurses aware for affective reasons, and four or 17.4 percent for cognitive reasons. One patient did not make the nurses aware for other reasons which was reflective of external conditions.

Table 22

Frequency and Percentage Distribution of Classification of Non-Reporting Behavior

Classification	Frequency	Percent
Affective	14	60.9
Cognitive	4	17.4
Psychomotor	2	8.7
No reason	2	8.7
Other	1	4.3

Affective domain rationales for not making the nurses aware of their feelings implied that patients were reluctant to express negative feelings or opinions about the nurses. Comments such as "didn't want to hurt the nurse's feelings" suggested that the patients did not want to appear ungrateful for their care or offend the staff. The majority of patients did not say anything to the nurses because they did not want to be labelled as a "troublemaker" or denied care. These feelings were evidenced by remarks such as "it seemed pointless because they treated everyone the same way," "thought the nurse would say to mind his own

business," "did not think it was my place to comment," and "did not want to get in an argument." Two patients stated that they tried to talk to the nurses "but it got worse and I did not want the nurse to take it out on me." Three patients stated that they did not think their concerns were "important enough" to speak to anyone about.

Two of the four patients who had a cognitive rationale for not making the nurses aware of their feelings believed that the nurse would not know the answers to the questions they had or would not tell them if they did. One patient was unable to identify that the unit supervisor might be the appropriate person to speak to about a concern related to the routines of that unit. The last patient was familiar with "the routine of how to get things" and went to the physician to obtain what was wanted.

Two patients provided psychomotor reasons for not making the nurses aware of their feelings. Both perceived themselves as too ill at the time to be able to speak with the nurses -- one being unable to speak and the other feeling very nauseous. Two patients perceived the nurses as being just "too busy" with other patients and felt that the nurses did not have time to listen to their concerns.

During the follow up interviews those patients who initially described a negative-effect incident described the same incident again. Six patients who had no response previously now described negative-effect incidents. No further attempts had been made by the patients to make the nurses aware of their feelings; however, one patient had written a letter to the Director of Nursing of the hospital. Further more, those patients who had not apprised the nurses of their feelings, again provided the same rationale for not doing so.

Of the six negative-effect incidents reported only at follow up, two were related to patient education and four were related to safety measures. Of the two patient education situations described, one was regarding the patient's inability to understand the teaching because the nurse used "too big of words" and stated that she "did not want the nurse to think she was stupid." The other situation was one in which the patient perceived that the nurses "did not tell you about your condition . . . or what is ahead of you . . . what is normal or not normal." When asked why he did not make the nurse aware of those feelings he replied that he "did not know if it was the nurses' job to tell the patient."

One patient commented that it took a long time for a nurse to answer the call bell and was concerned about what would happen in an emergency. The patient had not made the nurse aware of this concern because they had "enough trouble without bothering with this complaint," and since she did not need the nurse for an emergency that it "did not directly affect" her. Another patient stated that the nurses would not allow smoking in the room and since the patient was bedridden, had been unable to smoke. The patient thought that the hospital's rules should allow bedridden patients this freedom; however, he did not make the nurses aware of his feelings because "they were doing it for his own good." Two patients related incidents where they had been given the wrong dosage or wrong medication by a nurse and had noticed the error and notified the nurses. They expressed concern about other patients who were "not aware of what is going on" and "how often this happened." Both patients had told the nurse involved but had said no more because

"the nurse did something to correct the error immediatley" and "did not want to get anyone in trouble."

Critical Incidents Summary

The rank ordering of frequency of positive-effect and negative-effect incidents outlined in Table 23 was utilized to identify and compare those categories of incidents perceived by patients to be of a critical nature. Fifty-one of the fifty-three patients were able to identify and describe an event which they perceived to have a positive effect on their well-being. Psychosocial support measures, patient teaching and therapautic interventions were ranked as the three highest categories of nursing care activities. The two lowest ranking categories of nursing care activities were safety measures and hospital routines and environment.

Sixteen of fifty-two patients were unable to recall an event which they perceived to have a negative effect on their well-being. Therapeutic interventions and safety measures were ranked as the two highest categories of nursing care activities. Psychosocial support measures, patient teaching and hospital routines and environment ranked as the three lowest categories.

The frequency of reporting feelings about a critical incident to the nurse is summarized in Table 24. Apparently, the majority of patients made the nurse aware of positive feelings, but would not make the nurse aware of negative feelings.

The frequency and rank ordering of frequency of classifications of non-reporting behaviors for critical incidents is summarized in Table 25. The majority of patients gave reasons in the affective domain

Table 23

Frequency and Rank Order of Frequency of Positive-Effect and Negative-Effect Incidents Reported by Category

Positive-Effect Incidents			Negative-Effect Incidents		
Category	Frequency	Rank Order	Category	Frequency	Rank Order
Psychosocial Support Measures	22	1	No Response	16	1
Patient Teaching	15	2	Therapeutic Interventions	15	2
Therapeutic Interventions	9	3	Safety Measures	8	3
Safety Measures	4	4	Psychosocial Support Measures	5	4
No Response	2	5	Patient Teaching	4	5.5*
Hospital Routines and Environment	1	6	Hospital Routines and Environment	4	5.5*
Total	53		Total	52	

* Indicates tied rank

Table 24

Frequency of Reporting Positive-Effect and Negative-Effect Incidents

Positive-Effect Incidents		Negative-Effect Incidents	
Reported	Frequency	Reported	Frequency
Yes	38	No	23
No	13	Yes	7

Table 25

Frequency and Rank Order of Frequency of Classification of Non-Reporting Behaviors of Critical Incidents

Positive-Effect Incidents			Negative-Effect Incidents		
Classification	Frequency	Rank Order	Classification	Frequency	Rank Order
Affective	7	1	Affective	14	1
Other	4	2	Cognitive	4	2
Psychomotor	1	3.5*	Psychomotor	2	3.5*
No Response	1	3.5*	No Response	2	3.5*
Cognitive	0	5	Other	1	5
Total	13		Total	23	

* Indicates tied ranks

for not making the nurse aware of their feelings about either the positive-effect or negative-effect incident. Those reasons were reflective of values, interests, or attitudes that guided the patient not to apprise the nurses of their feelings.

Of the other six patients who did not report their feelings about the positive-effect incident, four provided rationales reflective of external conditions, while the other two patients were physically unable to or could not give a reason for not speaking to the nurse about the incident. There were no instances where the patient did not report their feelings because of lack of knowledge or understanding.

Of the other nine patients who had not reported their feelings about the negative-effect incident, four gave cognitive rationales for not doing so. They were reflective of a lack of understanding of whom to speak to, or the lack of comprehension of the consequences of the incident. Two patients felt physically unable to and two could not provide a reason for not speaking to the nurse. One patient's rationale was reflective of external conditions.

Summary

This chapter presented descriptive data gathered from the respondents. Frequency and percentage distributions were presented to describe the personal data of all respondents and to compare those respondents who experienced a medical or surgical intervention.

Ranking of items by means was employed to identify the level of satisfaction expressed prior to discharge, seven days following discharge and fourteen days following discharge, with the technical-professional, trusting relationship, and patient education dimensions of nursing care.

Incidents perceived by the patients to be critical were described using frequency and percentage distributions. Reporting behaviors were summarized and rationales for the behaviors were classified and reported using frequency and percentage distributions. Samples of comments representing critical incidents and rationales for non-reporting behaviors were presented.

Positive-effect and negative-effect incidents, reporting, and rationales for non-reporting behaviors were rank ordered by frequency. This provided further clarification of the types of incidents perceived by patients to be critical, and to identify factors which influenced the reporting of the patients' feelings about the quality of care provided.

CHAPTER FIVE

ANALYTICAL RESEARCH FINDINGS

This chapter contains the analytical research findings of the study. The chapter contains three sections: the first, discusses selected personal and demographic variables of the respondents and their expressed opinions relating to technical-professional care, trusting relationships, and patient education; the second presents the effect of time lapse on the expressed opinions of patients about the three dimensions of nursing care; and the final section presents a summary of the chapter.

Personal Data and Opinions of Nursing Care

Respondents were asked to indicate their level of agreement/ disagreement with items which were reflective of the care they received from the nurses. The items measured three dimensions of nursing care: technical- professional care, trusting relationships, and patient education. The statistical procedures of one-way analysis of variance, t-tests and correlated t-tests were used to test statistical differences in their opinions.

One-way analysis of variance is generally considered to be an appropriate statistical technique in a situation where interval data are available from more than two groups of respondents. When independent data are drawn from two groups, the t-test is considered appropriate; however, when the data from the two groups are not independent, the correlated t-test is the appropriate statistical technique. This

section identifies and discusses those items in which statistically significant mean differences occurred.

Hypothesis 1

The level of satisfaction with nursing care expressed by adult patients will not vary with age.

Five items had statistically significant mean differences on the basis of age and patients' opinions of nursing care according to Table 26. Of the five items, the first three shown were from the dimension of trusting relationships. The fourth item was from the technical-professional care dimension, and the last item was from the patient education dimension.

Patients who were 50 to 59 years old perceived that "the nurse is a person who can understand how I feel" more often than did the younger patients. Those individuals 60 years and older perceived that "when I need to talk to someone, I can go to the nurse with my problems" to a greater degree than did those patients 30 to 49 years old. Patients in the age group 50 to 59 agreed more than those aged 18 to 29 that "the nurse is too busy at the desk to spend time talking to me." Possibly, older patients perceived nurses as understanding and caring and wanting to spend more time talking with them than they do. One might assume that young adults are more impatient to have things done quickly as those patients 18 to 29 years old agreed more than patients 60 years of age and older that the nurses were too slow to do things for them. All individuals 30 years of age or older agreed that "the nurse always gives complete enough explanations of why tests are ordered," more than did

Table 26

One-Way Analysis of Variance of Patients' Opinions of Nursing Care on the Basis of Age

OPINION STATEMENT	MEAN SCORES				F Ratio	F Probability	Pairs significantly different at the 0.1 level*
	Group 1 18-29 (N=12)	Group 2 30-49 (N=12)	Group 3 50-59 (N=15)	Group 4 60 or older (N=14)			
The nurse is a person who can understand how I feel.	3.3	3.3	4.4	4.0	7.7	0.00	3 > 1, 2
When I need to talk to someone, I can go to the nurse with my problems.	3.8	3.5	4.1	4.4	2.9	0.04	4 > 2
The nurse is too busy at the desk to spend time talking with me.	2.8	3.5	3.9	3.4	2.9	0.04	3 > 1
The nurse is too slow to do things for me.	3.2	3.8	4.1	4.1	2.9	0.04	4 > 1
The nurse always gives complete enough explanations of why tests are ordered.	2.5	3.4	4.0	4.2	9.5	0.00	2, 3, 4 > 1

* Scheffe's procedure

those aged 18 to 29. It might be assumed that young adults expect more indepth explanation than older individuals expect.

However, on the remaining twenty items, age did not affect the perceived level of satisfaction expressed by patients about the nursing care.

Hypothesis 2

The level of satisfaction with nursing care expressed by adult patients will not vary with gender.

Table 27 shows that only one item in the trusting relationship dimension had a statistically significant mean difference on the basis of gender. Male patients ascribed greater agreement with "when I need to talk to someone, I can go to the nurse with my problems," than did female patients. It appears that gender does not affect the perceived level of satisfaction with nursing care.

Table 27

T-Tests of Patients' Opinions of Nursing Care on the Basis of Gender

OPINION, STATEMENT	GENDER	MEAN	T-VALUE	PROBABILITY
When I need to talk to someone, I can go to the nurse with my problems.	M	4.2	2.09	0.04
	F	3.8		

Hypothesis 3

The level of satisfaction with nursing care expressed by adult patients will not vary with marital status.

On the basis of marital status, three items had statistically significant mean differences for opinions of nursing care, as shown in Table 28. The first item was from the trusting relationship dimension and the other two were about the technical-professional care. For all three items, "the nurse should be more attentive than he/she is," "the nurse really gives good advice," and "the nurse really knows what he/she is talking about," married patients agreed more than did other patients. It would appear that married patients were more willing to listen and accept advice from nurses whom they perceived to be knowledgeable, but still would like more attention paid to them. On all remaining items, marital status did not affect the perceived level of satisfaction with nursing care.

Table 28

T-Tests of Patients' Opinions of Nursing Care on the Basis of Marital Status

OPINION STATEMENT	MARITAL STATUS	MEAN	T-VALUE	PROBABILITY
The nurse should be more attentive than he/she is.	M	4.0	2.17	0.03
	O	3.4		
The nurse gives good advice.	M	4.1	2.56	0.01
	O	3.5		
The nurse really knows what he/she is talking about.	M	4.0	2.25	0.03
	O	3.7		

Hypothesis 4

The level of satisfaction with nursing care expressed by adult patients will not vary with the experience of a surgical intervention.

As Table 29 indicates, four items had statistically significant mean differences for opinions of nursing care on the basis of type of intervention. Of the four items, the first two shown were from the trusting relationship dimension. The third was about patient education, and the fourth related to technical-professional care.

Those patients who experienced a medical intervention agreed more than did those patients experiencing a surgical intervention on all four items. The items were (1) when I need to talk to someone, I can go to the nurse with my problems, (2) just talking to the nurse makes me feel better, (3) the nurse always gives complete enough explanations of why tests are ordered, (4) the nurse is too slow to do things for me. This finding is not surprising since the medical patients were mainly 50 years of age and older, and less well educated than surgical patients. Older, poorly educated individuals are often considered to have lower expectations and to be more forebearing than those who are younger and better educated.

For the other items the type of intervention did not affect the patients' expressed level of satisfaction with nursing care.

Hypothesis 5

The level of satisfaction with nursing care expressed by adult patients will not vary with attained educational level.

Table 30 shows the degree of agreement with items of nursing care on the basis of level of education. Only one item, from the dimension

of trusting relationships, showed a significant difference by level of educational attainment. Those patients who had grade 1 to 9 education perceived that "the nurse is too busy at the desk to spend time talking to me" more than those who had postsecondary education. Perhaps those patients better educated have a keener conception of the operation and organization of a unit within a large organization and place less importance on the time spent talking with the nurse. On all remaining items, level of education attained did not affect the perceived level of satisfaction with nursing care.

Table 29

T-Tests of Patients' Opinions of Nursing Care on the Basis of Type of Intervention

OPINION STATEMENT	TYPE OF INTERVENTION	MEAN	T-VALUE	PROBABILITY
When I need to talk to someone, I can go to the nurse with my problems.	M*	4.3	2.82	0.01
	S*	3.7		
Just talking to the nurse makes me feel better.	M	4.3	2.63	0.01
	S	3.7		
The nurse always gives complete enough explanations of why tests are ordered.	M	3.9	2.43	0.02
	S	3.3		
The nurse is too slow to do things for me.**	M	4.1	2.31	0.03
	S	3.6		

* M and S denote medical and surgical, respectively.
** This item was reflected in the computation of means.

Table 30

One-Way Analysis of Variance of Patients' Opinions of Nursing Care on the Basis of Level of Education Attained

OPINION STATEMENT	MEAN SCORES			F Ratio	F Probability	Pairs significantly different at the 0.1 level*
	Group 1 Grade 1-9	Group 2 Grade 10-12	Group 3 Post-secondary			
The nurse is too busy at the desk to spend time talking with me.	3.7	3.6	2.9	2.9	0.1	1 > 3

* Scheffe' procedure

Hypothesis 6

The level of satisfaction with nursing care expressed by adult patients will not vary with admission status.

Table 31 shows that patients admitted electively to hospital agreed more to "just talking to the nurse makes me feel better" than did those patients admitted as an emergency. Perhaps those patients admitted as emergencies perceived themselves as being more ill and placed less value on talking with the nurse as a means to feeling better. This item, from the dimension trusting relationships, was the only item on which admission status was perceived to affect patient satisfaction. On all remaining items, however, admission status was not perceived to affect the level of satisfaction with nursing care.

Table 31

T-Tests of Patients' Opinions of Nursing Care on the Basis of Admission Status

OPINION STATEMENT	ADMISSION STATUS	MEAN	T-VALUE	PROBABILITY
Just talking to the nurse makes me feel better.	Elective	3.7	-2.28	0.03
	Emergency	4.2		

Hypothesis 7

The length of time between the most recent hospitalization and the present one will not have an effect on the level of satisfaction with nursing care expressed by adult patients.

On the basis of previous hospitalizations, items in the three dimensions of nursing care did not have statistically significant mean

differences. Therefore, the level of satisfaction with nursing care expressed by adult patients was not affected by length of time since last hospitalization.

Hypothesis 8

The level of satisfaction with nursing care expressed by adult patients who are health care workers will not vary from those patients who are not. This hypothesis was not tested because only one of the fifty-three patients was employed as a health care worker.

Hypothesis 9

The level of satisfaction with selected aspects of nursing care expressed by adult patients will not vary from the day of discharge to that expressed at 7 days or 14 days following discharge from the hospital.

The comparison of the opinions for those patients assigned to Group I for seven day follow up with those patients assigned to Group II for fourteen day follow up indicated that the two groups' opinions were similar at the time of discharge. Therefore, it can be assumed that the randomization procedure for assigning the patients to groups for follow up was effective.

There were no statistically significant mean differences in the level of opinions of nursing care expressed by Group I patients prior to discharge from the hospital as compared with that expressed seven days following discharge from the hospital.

The comparison of opinions of Group II patients indicates that three items had statistically significant mean differences, as shown in Table 32. The first two items were from the trusting relationships and

the other from the patient education dimension. For all three items, "a person feels free to ask the nurse questions," "when I need to talk to someone I can go to the nurse with my problems," and "too often the nurse thinks you can't understand the medical explanation of your illness, so he/she just doesn't bother to explain" the opinion of nursing care had decreased significantly at fourteen days following discharge.

Table 32

Correlated T-Tests of Patients' Opinions of Nursing Care for Group II

OPINION STATEMENT	TIME (Days)	MEAN	T-VALUE	PROBABILITY
A person feels free to ask the nurse questions.	0	4.4	2.87	0.01
	14	4.1		
When I need to talk to someone, I can go to the nurse with my problems.	0	4.0	2.13	0.04
	14	3.6		
Too often the nurse thinks you can't understand the medical explanation of your illness, so he/she just doesn't bother to explain.	0	4.0	2.78	0.01
	14	3.5		

It appears that the level of satisfaction with nursing care expressed by patients does not vary significantly at seven days following discharge, but by fourteen days following discharge the level of satisfaction is less than that expressed prior to discharge from

hospital, on two items on the trusting relationship and one item on patient education dimensions. The passage of time does not appear to affect the level of satisfaction with technical-professional care provided by the nurses to the patients.

SUMMARY

This chapter presented the data gathered from respondents as it related to the hypotheses posed for the study. T-tests and one-way analysis of variance were used to identify and describe statistically significant mean differences in the opinions of respondents regarding personal and demographic characteristics and the level of satisfaction with selected aspects of nursing care.

Correlated t-tests were presented to determine statistically significant mean differences in the respondents' opinions expressed prior to discharge, at seven days and at fourteen days following discharge from the hospital regarding selected aspects of nursing care.

CHAPTER SIX

SUMMARY, CONCLUSIONS AND IMPLICATIONS

This chapter includes the summary, conclusions and implications of the study. The initial section of the chapter provides a summarization of the study, including its purpose, methodology, data analysis and findings. The second section presents the conclusions derived from the findings. The final section deals with some implications for health care providers and administrators and for further research.

Summary

Health care administrators and practitioners strive to provide quality care for patients. At the same time, patients expect to receive quality care. What comprises patients' specific expectations are largely unknown but have been speculated upon in the literature. Legal, professional, consumer and institutional bodies have developed documents such as statements of professional ethics and consumer rights, standards of practice, regulations, and policies and procedures to guide practitioners in providing that quality of care.

Patients are the reason for health care facilities and professionals and, therefore, they should expect a helping relationship from their care providers. It is the patient's right to make comments regarding those aspects of care received. Such comments reflect their level of satisfaction with those aspects of care.

Purpose

Four purposes for this study were identified. They were:

1. To determine the level of patient satisfaction with the technical-professional and educational aspects of nursing care, and the level of trust which the patient has in the nurses providing care.

2. To examine demographic and other selected variables which may affect the nature of patient satisfaction with nursing care.

3. To identify factors which may influence the reporting of the patient's opinion about the quality of care received.

4. To determine the effect of time lapse on the expressed level of patient satisfaction.

Hypotheses

The following hypotheses were addressed in this study:

1. The level of satisfaction with nursing care expressed by adult patients will not vary with age;

2. The level of satisfaction with nursing care expressed by adult patients will not vary with gender;

3. The level of satisfaction with nursing care expressed by adult patients will not vary with marital status;

4. The level of satisfaction with nursing care expressed by adult patients will not vary with the experience of a surgical intervention;

5. The level of satisfaction with nursing care expressed by adult patients will not vary with attained educational level;

6. The level of satisfaction with nursing care expressed by adult patients will not vary with admission status;

7. The length of time between the most recent hospitalization and the present one will not have an effect on the level of satisfaction expressed by adult patients;

8. The level of satisfaction with nursing care expressed by adult patients who are health care workers will not vary from those patients who are not; and

9. The level of satisfaction with selected aspects of nursing care expressed by adult patients will not vary from the day of discharge to that expressed at 7 days or 14 days following discharge from the hospital.

Methodology

The research guide developed for data collection consisted of five sections. The first section related to personal and sociodemographic data; the second and fourth sections used a questionnaire relating to technical-professional and educational aspects of nursing care, and the level of trust which the patient had in the nurses providing care; and the third and fifth sections used an interview guide describing critical incidents experienced during hospitalization and the related reporting behaviors, and an expressed level of overall satisfaction with nursing care. Sections I, II and III were completed by patients prior to discharge from hospital, and Sections IV and V for follow up.

Individuals selected to participate in this investigation were adult patients who had been acutely ill on admission to one urban tertiary care hospital, experienced either a medical and/or surgical intervention, and were hospitalized for more than two and less than fourteen days. Respondents were required to be English literate,

mentally competent, reside within a 25 mile radius of the city, and be accessible by telephone for fourteen days following discharge from the hospital. Once included in the study, subjects were randomly assigned to Group I for 7 day follow up or Group II for 14 day follow up.

Data Analysis

Frequency and percentage distributions were used to describe the personal data of all respondents, those experiencing a medical intervention and those experiencing a surgical intervention.

Ranking of items by means was performed to identify those aspects of care within the technical-professional care, trusting relationship, and patient education dimensions perceived as satisfying prior to discharge, 7 days, and 14 days following discharge.

Rank ordering of frequencies was used to describe categorized critical incidents, categorized non-reporting behaviors and reporting of incidents.

One-way analysis of variance and t-tests were used to determine statistically significant mean differences among the opinions of respondents regarding satisfaction with technical-professional care, the trusting relationship and patient education on the basis of age, gender, marital status, previous hospitalization, admission status, level of education, type of intervention and differences between Group I and Group II prior to discharge and again at follow up.

Correlated t-tests were used to determine statistically significant mean differences of opinion regarding satisfaction with technical-professional care, the trusting relationship, and patient education initially and at the time of follow up of Group I and Group II respondents.

Critical incidents were categorized under the headings: safety measures, therapeutic interventions, psychosocial support measures, patient teaching, and hospital routines and environment. Rationales for non-reporting behaviors were categorized under the headings of cognitive, affective, psychomotor, and other.

Findings

Personal and demographic data profile. Slightly more than one-half of the respondents were 50 years of age or older, female, and married. The vast majority of the respondents were non-health care workers and had experienced a previous hospitalization. Slightly more than one-half were admitted to hospital as requiring emergency care. Slightly less than one-half of the respondents had attained Grade 10 to 12 as their highest level of education. Grade 1 to 9 or postsecondary education was equally attained by the others. Random assignment for follow up after discharge placed 27 of the respondents into the 14-day follow up group and the others in the 7-day follow up group.

Personal data profiles were further compared to describe the medical and surgical respondents and to clarify any differences which were present. The 24 medical respondents were older than the 29 surgical respondents. An equal number of the medical respondents were male and female, while slightly more of the surgical respondents were female. The married patients were the majority for both medical and surgical respondents.

The only health care worker contained in the study experienced a surgical intervention. All medical respondents were previously hospitalized, with the greatest percentage (79.2%) within the previous

five years. Of the previously hospitalized surgical respondents, about one-half were hospitalized within the last five years. The majority of admissions for both groups were for emergency reasons. The highest level of education attained by medical respondents was lower than that of surgical respondents.

Opinions of Nursing Care. Patients' opinions of nursing care were measured prior to discharge, seven days after discharge, and fourteen days after discharge.

1. Perceptions prior to discharge. Patients were satisfied with all aspects of technical-professional care and generally satisfied with the trusting relationship and patient education. They expressed uncertainty about the nurses being too busy at the desk to spend time talking with them and that nurses did not tell them enough about the results of their tests.

2. Perceptions seven days after discharge. Patients were satisfed with all aspects of technical-professional care and trusting relationships. They expressed uncertainty about the nurses telling them more about the results of their tests but were otherwise satisfied with patient education.

3. Perceptions fourteen days after discharge. Patients were satisfied with the technical-professional care received. The trusting relationship was perceived as generally satisfying with some uncertainty expressed about nurses' understanding of how they felt and the nurses being too busy at the desk to spend time talking with them. Patients were only slightly satisfied with patient education. Uncertainty was

expressed regarding the lack of explanations about their medical illnesses, why tests were ordered, and the results of those tests.

Critical Incidents and Reporting Behaviors. Incidents perceived by patients to have a positive-effect and negative-effect on their well-being and the associated reporting behaviors were described.

1. Postive-effect incidents. Two-fifths of the respondents reported incidents about psychosocial support measures. In decreasing frequency, patient-teaching, therapeutic interventions, safety measures, and hospital routines and environment incidents were reported.

Three quarters of the patients had made the nurses aware of their feelings and had done so by speaking with the nurses personally. Of those who did not make the nurses aware of their feelings, the majority (84.6%) were for affective or other reasons which reflected external conditions.

During the follow-up interviews patients described the same incidents and rationales as they had previously. No further attempts had been made by the patients to make the nurses aware of their feelings.

2. Negative-effect incidents. Less than one-half of the respondents (43.4%) stated they experienced no negative-effect incidents. In decreasing frequency, therapeutic interventions, psychosocial support measures, safety measures, hospital routines and environment and patient teaching incidents were reported.

About three quarters of the patients had not made the nurses aware of their feelings. Of those who did not make the nurses aware of their feelings, the majority were for affective or cognitive reasons. Those

who had reported their feelings about the incidents had done so by speaking to the nurses personally or with the unit supervisor.

During the follow-up interviews those patients who initially described an incident described the same incident again. Six patients who had not responded previously now described an incident. Four were related to safety measures and two were related to patient teaching. No further attempts had been made by the patients to make the nurses aware of their feelings, however, one patient had written a letter to the Director of Nursing of the hospital.

Personal and Demographic Variables and Opinions of Nursing Care. Patient's opinions of nursing care were compared with several personal and demographic variables to determine their significance.

1. Age. Age was statistically significant in five of the twenty-five items regarding opinions of nursing care. Three were related to the trusting relationship, and one each from the technical-professional and patient education dimensions. It appeared that as age increased, patients perceived nurses as more understanding, and wanting to spend more time talking with them, were more patient in having things done quickly, and required less indepth explanations.

2. Gender. Only one item was statistically significant for gender. When males needed to talk to someone, they would go to the nurse with their problems, whereas females would not.

3. Marital Status. On the basis of marital status, three items had statistically significant mean differences of opinions of nursing care. One was about the trusting relationship and the other two about technical-professional care. Married patients agreed more than did

other patients that the nurses should be more attentive, gave good advice, and knew what he/she was talking about.

4. Type of Intervention. Four items were statistically significant on the basis of type of intervention: two were about the trusting relationship, and one each about patient education and technical-professional care. Medical patients were more likely to talk to the nurses about their problems and feel better when talking to the nurses. They also accepted the explanations of why tests were ordered and the speed with which nurses did things for them, more readily than did surgical patients.

5. Educational Level. On only one item from the trusting dimension was the level of satisfaction significantly influenced by educational level. Patients who had grade 1 to 9 education perceived nurses to be too busy at the desk to spend time talking to them, more than those who had postsecondary education.

6. Admission Status. Patients admitted electively to hospital agreed more that just talking to the nurse made them feel better than did those patients admitted as an emergency. This item from the trusting dimension was the only one which was statistically significant.

7. Length of Time Between Hospitalization Experiences. On the basis of length of time between the most recent hospitalization and the present one there were no statistically significant mean differences of opinions of nursing care.

8. Health Care Workers. This variable was not tested as only one subject contained in the sample was employed as a health care worker.

9. Time Lapse. The randomization procedure for assigning patients into follow up groups was effective as there were no statistically significant mean differences between groups' opinions of nursing care prior to discharge.

There were no statistically significant mean differences in the opinions of nursing care expressed by patients seven days following discharge as compared to those opinions expressed prior to discharge.

Three items, two regarding the trusting relationship and the other about patient education had statistically significant mean differences fourteen days following discharge as compared to prior to discharge. Their opinions about freedom to ask the nurse questions, feeling they could go to the nurse with their problems, and the lack of explanations about their medical illnesses had declined by fourteen days following discharge.

Conclusions

The following conclusions were based on the findings of the study.

Overall Level of Satisfaction

Patients directly expressed an overall level of satisfaction with the care they received from the nurses. The level of satisfaction ranged from satisfied to very satisfied. This finding is consistent with that of other patient satisfaction research.

Time lapse had no effect on the overall level of satisfaction expressed directly by patients.

Dimensions of Care.

Patients expressed satisfaction with the technical-professional care received and time lapse had no effect on this dimension. Patients were generally satisfied with the trusting relationship; however, the overall level of satisfaction declined over the two week period following discharge from hospital. Patients were slightly satisfied with the educational aspects of their care and the overall level of satisfaction declined over the two week time period following discharge.

For all dimensions of care the variation in opinions expressed by patients was greatest prior to discharge and tended to decrease somewhat by 14 days. Time lapse did not affect the rank ordering of levels of satisfaction with the dimensions of care. Consistently, technical-professional care ranked highest, followed by the trusting relationship and patient education.

Critical Incidents and Reporting Behaviors.

Patients were generally able to identify and describe an event which they perceived to have a positive-effect on their well-being. In order of frequency, the incidents were related to psychosocial support measures, patient teaching, therapeutic interventions, safety measures, and hospital routines and environment. It was interesting to note the frequency with which patient teaching events were cited as a positive event when the overall level of satisfaction with the patient education dimension was only slightly satisfying. The majority of patients made the nurses aware of positive feelings by speaking to them directly. Of those who did not make the nurses aware of their feelings, they said it was because they experienced difficulty expressing feelings.

Time lapse did not affect the positive-effect event which was reported. Once discharged from hospital, patients made no further attempts to inform the nurses of their feelings.

One-third of the patients were unable to identify and describe an event which they perceived to have a negative-effect on their well-being prior to discharge. In order of frequency the incidents reported were related to therapeutic interventions, safety measures, psychosocial support measures, patient teaching and hospital routines and environment. The majority of patients did not make the nurses aware of their negative feelings. The majority of those patients said it was because they did not want to be labelled as a troublemaker or denied care while others said it was because they did not want to hurt the nurse's feelings.

Time lapse did not affect the negative-effect incident which was reported but it did affect the number of incidents reported as six more events were reported at follow up. Once discharged from hospital, patients generally made no further attempt to inform the nurses of their feelings. The one patient who consistenty expressed dissatisfaction with the nursing care had addressed a letter to the Director of Nursing of the hospital.

Personal and Demographic Variables

The significance of personal and demographic variables to patient satisfaction was inconclusive. Some minor effect was demonstrated with the variables of age, marital status, type of intervention experienced, and a two week time lapse. All other variables, including gender, educational level, admission status, length of time between

hospitalization experiences, and a one week time lapse demonstrated no significant effect on the level of patient satisfaction.

Implications

The data provided by this investigation resulted in some significant findings; however, it is recognized that much more empirical work is needed in this research area. Suggestions concerning implications for health care providers must, therefore, be regarded cautiously.

Implications for Health Care Providers

The findings of this study indicate that patients expressed an overall level of satisfaction with the care they received from the nurses. As an accurate and distinct measure of quality of care the value of an overall level of patient satisfaction must be questioned. Patients were able to describe specific incidents and make observations of nurses and the care they provided which yielded a measure of quality care which would otherwise have been lost.

Patients were satisfied with many apects of the nursing care they received. Patients' opinions suggested that improvements could be made in all aspects of patient teaching and several aspects of the trusting relationship and technical-professional care. Concerns such as these over time could have a negative impact on nurses individually and for the profession as a whole. This finding might imply that the nursing profession should take action to improve its image with the patient population as well as the general public. Such action could possibly include (1) placing more emphasis on nurse's basic and continuing education in the areas of patient teaching, communication and

other human relations skills, physiology and pathophysiology; and (2) advocating that nursing and hospital administration recognize and actively support patient teaching and interpersonal communication as necessary factors in providing quality patient care.

The findings indicate that time lapse does not affect the rank ordering of satisfaction with dimensions of nursing care but that the level of that satisfaction declines somewhat over time. Patients reported more negative-effect incidents following discharge than they reported while in hospital. This suggests that patients were reluctant to express negative opinions about their care. Some expressed the fear of being labelled as a troublemaker and denied care while others depreciated their needs in favor of other patients. This finding supports concerns discussed in the literature, but previously unreported as a research finding.

Patients apparently will provide positive feedback directly to the caregiver in most instances. Contrary to this, patients are unlikely to express negative feedback directly to the caregiver or to nursing administration. This may be because they do not want to get the caregiver in trouble or because they do not know to whom they should direct these concerns. This finding might imply nursing administration could make patients aware of the communication channels available to them in the hospital. Further, when nursing administration seeks feedback from patients about quality of care, information should be requested anonymously, shortly following discharge, with specific questions asked rather than with overall ratings of care.

The findings of this study provides little substantive evidence regarding personal and sociodemographic variables as they affect

satisfaction with nursing care. Generally, older (50 years and over), married medical patients were more satisfied than their counterparts. Level of education, admission status, gender, and history of hospitalization did not relate significantly to level of satisfaction. This finding might imply that health care providers need not focus their attention on these factors until new evidence is provided to the contrary.

Implications for Research

Although this study provided some useful information regarding the effects of time lapse on patient satisfaction and reporting of critical incidents, further research in the area might either support or refute the conclusions of this study. While it appears a great deal remains to be learned about all the variables and relationships with which this study was concerned, further research regarding nurse/patient relationships in health care might expand the data base as follows:

1. Replication of this study with a larger sample to include other urban hospitals to determine if perceptions of the nursing care received by patients differ significantly from the findings of this study.

2. Replication of this study involving urban and rural, teaching and non-teaching hospitals to determine if patients' perceptions differ significantly from the findings of this study.

3. Replication of this study using similar and extended time periods for follow up is needed to better approximate the time at which most valid and reliable indications of patient satisfaction can be obtained.

4. Determine patients' expectations of nursing care prior to and following hospitalization to ascertain if the dimensions of care studied are valid.

5. Further research should be conducted to define the relationship between expectations and outcomes of care to determine its effects on patient satisfaction.

6. Further research should be conducted using the critical incident technique to identify events which patients perceive to facilitate and detract from the nurse/patient relationship.

7. Further research is needed using the critical incident method or other methodologies to examine the reporting behaviors of patients.

8. Further research is needed to develop a theory and universal definition of patient satisfaction.

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APPENDIX A

RESEARCH GUIDE

PATIENT'S OPINION OF NURSING CARE

SECTION I: PERSONAL DATA

CODE # _____

TELEPHONE NUMBER: HOME: _____ WORK: _____

MAILING ADDRESS: _____

_____

AGE: _____ 5,6

GENDER: 1. MALE _____ 2. FEMALE _____ 7

MARITAL STATUS: 1. M _____ 2. S _____ 3. W _____ 8

4. D _____ 5. OTHER _____

HEALTH CARE WORKER: 1. YES _____ 2. NO _____ 9

1. ACTIVE _____ 2. INACTIVE _____ 10

TYPE: _____

PREVIOUSLY HOSPITALIZED?: 1. YES _____ 2. _____ 11

1. 1980 to 1984 (within the last 5 years) _____

2. 1975 to 1979 (from 5 to 10 years ago) _____ 12

3. Prior to 1975 _____

ADMISSION STATUS: 1. ELECTIVE _____ 2. EMERGENCY _____ 13

HIGHEST EDUCATION LEVEL ATTAINED: 1. Grade 1 to 9 _____ 14

2. Grade 10 to 12 _____

3. Post-secondary _____

DATE OF DISCHARGE: (0) _____

DATE OF FOLLOW-UP INTERVIEW: 1. Seven days _____ 15

2. Fourteen days _____

Code #_____

PATIENT'S OPINION OF NURSING CARE

SECTION II: QUESTIONNAIRE

Please give your honest opinion for each statement on this list by circling one of the five answers to describe the nurse(s) caring for you:

1. The nurse should be more attentive than he/she is.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	5

2. Too often the nurse thinks you can't understand the medical explanation of your illness, so he/she just doesn't bother to explain.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	6

3. The nurse is pleasant to be around.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	7

4. A person feels free to ask the nurse questions.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	8

5. The nurse should be more friendly than he/she is.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	9

6. The nurse is a person who can understand how I feel.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	10

7. The nurse explains things in simple language.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	11

Patient's Opinion of Nursing Care
Page 2

8. The nurse asks a lot of questions, but once he/she finds the answers, he/she doesn't seem to do to anything.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	12

9. When I need to talk to someone, I can go to the nurse with my problems.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	13

10. The nurse is too busy at the desk to spend time talking with me.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	14

11. I wish the nurse would tell me about the results of my test more than he/she does.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	15

12. The nurse makes it a point to show me how to carry out the doctor's orders.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	16

13. The nurse is often too disorganized to appear calm.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	17

14. The nurse is understanding in listening to a patient's problems.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	18

Patient's Opinion of Nursing Care
Page 3

15. The nurse gives good advice.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	19

16. The nurse really knows what he/she is talking about.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	20

17. It is always easy to understand what the nurse is talking about.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	21

18. The nurse is too slow to do things for me.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	22

19. The nurse is just not patient enough.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	23

20. The nurse is not precise in doing his/her work.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	24

21. The nurse gives directions at just the right speed.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	25

22. I'm tired of the nurse talking down to me.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	26

Patient's Opinion of Nursing Care
Page 4

23. Just talking to the nurse makes me feel better.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	27

24. The nurse always gives complete enough explanations of why tests are ordered.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	28

25. The nurse is skillful in assisting the doctor with procedures.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	29

Adapted from N. Risser, Nursing Research, 1975.
A.S. Hinshaw, R.N., Ph.D.
J.R. Atwood, R.N., Ph.D.
Nursing Department, University Hospital

Code #_____

PATIENT'S OPINION OF NURSING CARE

SECTION III: INTERVIEW GUIDE

1. Can you recall one thing the nurse(s) said or did that you found to be beneficial, made your stay more pleasant, or that helped you the most while you were in the hospital? Explain. 5,6

2. Did you let the nurses(s) know what helped you the most? 7
   1. Yes _____ 2. No _____

   IF THE SUBJECT ANSWERED YES TO QUESTION #2 PROCEED TO QUESTION #3. HOWEVER, IF THE SUBJECT ANSWERED NO TO QUESTION #2 PROCEED TO QUESTION #4.

3. How did you let the nurse(s) know?

   1. _____ Talked to the nurse(s) personally.
   2. _____ Sent a token of appreciation (eg. a gift).
   3. _____ Sent a thank you note.
   4. _____ Others. 8

4. Can you tell me why you didn't let the nurse(s) know that you found that action to be helpful? 9,10

PROCEED TO QUESTION #5.

Patient's Opinion of Nursing Care
Page 2

5. Can you recall one thing the nurse(s) said or did that you found to be detrimental, made your stay less pleasant, or that helped you the least while you were in the hospital? Explain.

11,12

6. Did you let the nurse(s) know what helped you the least?
   1. Yes _____ 2. No _____

IF SUBJECT ANSWERED YES TO QUESTION #6 PROCEED TO QUESTION #7. IF SUBJECT ANSWERED NO TO QUESTION #6 PROCEED TO QUESTION #8.

13

7. How did you let the nurse(s) know?

   1. _____ Talked to the nurse(s) personally.
   2. _____ Talked to the head nurse.
   3. _____ Sent a letter to, or talked to the Director of Nursing.
   4. _____ Sent a letter to, or talked to the Administrator.
   5. _____ Complained to my Doctor.
   6. _____ Others.

14

8. Can you tell me why you didn't let the nurse(s) know that you found that action not to be helpful?

15,16

PROCEED TO QUESTION #9 AND #10

Patient's Opinion of Nursing Care
Page 3

9. Would you say you were satisfied with the nursing care you received?
   1. Yes _____ 2. No _____ 17

10. How satisfied were you with the care you have received from the nurses?

   1. _____ Very satisfied
   2. _____ Satisfied
   3. _____ Uncertain
   4. _____ Dissatisfied
   5. _____ Very dissatisfied 18

Code #_____

PATIENT'S OPINION OF NURSING CARE

SECTION IV: QUESTIONNAIRE

Please give your honest opinion for each statement on this list by circling one of the five answers to describe the nurse(s) caring for you:

1. The nurse should be more attentive than he/she is.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	5

2. Too often the nurse thinks you can't understand the medical explanation of your illness, so he/she just doesn't bother to explain.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	6

3. The nurse is pleasant to be around.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	7

4. A person feels free to ask the nurse questions.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	8

5. The nurse should be more friendly than he/she is.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	9

6. The nurse is a person who can understand how I feel.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	10

7. The nurse explains things in simple language.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	11

Patient's Opinion of Nursing Care
Page 2

8. The nurse asks a lot of questions, but once he/she finds the answers, he/she doesn't seem to do to anything.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	12

9. When I need to talk to someone, I can go to the nurse with my problems.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	13

10. The nurse is too busy at the desk to spend time talking with me.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	14

11. I wish the nurse would tell me about the results of my test more than he/she does.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	15

12. The nurse makes it a point to show me how to carry out the doctor's orders.

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STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	16

13. The nurse is often too disorganized to appear calm.

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14. The nurse is understanding in listening to a patient's problems.

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STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	18

Patient's Opinion of Nursing Care
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15. The nurse gives good advice.

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16. The nurse really knows what he/she is talking about.

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STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	20

17. It is always easy to understand what the nurse is talking about.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	21

18. The nurse is too slow to do things for me.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	22

19. The nurse is just not patient enough.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	23

20. The nurse is not precise in doing his/her work.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	24

21. The nurse gives directions at just the right speed.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	25

22. I'm tired of the nurse talking down to me.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	26

Patient's Opinion of Nursing Care
Page 4

23. Just talking to the nurse makes me feel better.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	27

24. The nurse always gives complete enough explanations of why tests are ordered.

5	4	3	2	1	
STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	28

25. The nurse is skillful in assisting the doctor with procedures.

5	4	3	2	1	
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J.R. Atwood, R.N., Ph.D.
Nursing Department, University Hospital

Code #_____

PATIENT'S OPINION OF NURSING CARE

SECTION V: INTERVIEW GUIDE

1. Can you recall one thing the nurse(s) said or did that you found to be beneficial, made your stay more pleasant, or that helped you the most while you were in the hospital? Explain. 5,6

2. Did you let the nurses(s) know what helped you the most? 7
   1. Yes _____ 2. No _____

   IF THE SUBJECT ANSWERED YES TO QUESTION #2 PROCEED TO QUESTION #3. HOWEVER, IF THE SUBJECT ANSWERED NO TO QUESTION #2 PROCEED TO QUESTION #4.

3. How did you let the nurse(s) know?

   1. _____ Talked to the nurse(s) personally.
   2. _____ Sent a token of appreciation (eg. a gift).
   3. _____ Sent a thank you note.
   4. _____ Others. 8

4. Can you tell me why you didn't let the nurse(s) know that you found that action to be helpful? 9,10

PROCEED TO QUESTION #5.

Patient's Opinion of Nursing Care
Page 2

5. Can you recall one thing [redacted] nurse(s) said or did that you found to be detrimental, made your stay less pleasant, or that helped you the least while you were in the hospital? Explain.

11,12

6. Did you let the nurse(s) know what helped you the least?
1. Yes _____ 2. No _____

IF SUBJECT ANSWERED YES TO QUESTION #6 PROCEED TO QUESTION #7. IF SUBJECT ANSWERED NO TO QUESTION #6 PROCEED TO QUESTION #8.

13

7. How did you let the nurse(s) know?

1. _____ Talked to the nurse(s) personally.
2. _____ Talked to the head nurse.
3. _____ Sent a letter to, or talked to the Director of Nursing.
4. _____ Sent a letter to, or talked to the Administrator.
5. _____ Complained to my Doctor.
6. _____ Others.

14

8. Can you tell me why you didn't let the nurse(s) know that you found that action not to be helpful?

15,16

PROCEED TO QUESTION #9 AND #10

Patient's Opinion of Nursing Care
Page 3

9. Would you say you were satisfied with the nursing care you received?
   1. Yes _____ 2. No _____ | 17

10. How satisfied were you with the care you have received from the nurses?

    1. _____ Very satisfied
    2. _____ Satisfied
    3. _____ Uncertain
    4. _____ Dissatisfied
    5. _____ Very dissatisfied | 18

APPENDIX B

CORRESPONDENCE

September 13, 1984

Dear :

I am submitting a research proposal for review by the _____ Hospital . Accompanying this letter are 15 copies of the research proposal and a letter to the Clinical Investigation Committee members indicating acceptance of the proposal by my Thesis Committee.

Thank you for considering this study for selection through the _____ Hospital.

Sincerely,

Marie Lyle

Marie Lyle
M. Education Candidate
Principal Investigator
Phone: 437-4879 (home)
477-4219 (work)

attach.
ML/bls

September 11, 1984

Dear

I am pleased to write in support of Ms. Marie Lyle's request to gather data for her graduate research on "Measurement of Patient Satisfaction with Selected Aspects of Nursing Care." As chairman of her thesis committee, I wish to inform you that Ms. Lyle successfully defended her proposal on June 25, 1984, and that proposed study has been approved. Other members of her thesis committee include Ms. Donna Smith, Director of Nursing, University of Alberta Hospitals and Assistant Professor, Faculty of Nursing, University of Alberta and Dr. R.G. McIntosh, Professor of Educational Administration.

The proposed study is of significance to knowledge development in nursing and has practical value in the health care professions. As this will be the first descriptive study of this nature conducted in Alberta, we anticipate with pleasure the opportunity to gather data at the _____ _____ Hospital.

If you have any questions or concerns regarding the proposed study and/or the qualifications of the investigator, please feel free to contact me.

Cordially,

Abram G. Konrad
Professor

AGK/rdv

November 8, 1984

Ms Marie Lyle
MN Student
Dept. Educational Administration
7-104 Education North
University of Alberta
Edmonton, Alberta

Dear Ms Lyle:

I am pleased to inform you that your protocol "Measurement of Patient Satisfaction with Selected Aspects of Nursing Care" was approved by the Clinical Investigation Committee at their meeting of October 9, 1984 with the proviso that the Consent Form be modified such that the patients will not be sent a summary of the results of the study.

The Medical Advisory Board of the _____ Hospital has passed a motion which requires all investigators to submit the results of their research to the Chairman of the Quality Control Committee and Chairman of the Clinical Investigation Committee.

Yours truly,

APPENDIX C

SUBJECT CONSENT

Code # _____

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

"Patient's Opinion of Nursing Care"

Research Project Supervisor: Dr. A. Konrad, Professor
Department of Educational Administration
University of Alberta

Principal Investigator: Ms. Marie Lyle R.N., B.Sc.N.
Candidate for Masters of Education
Phone: 437-4879 (home)

I am interested in your opinion of the nursing care received while you were a patient in the hospital. Obtaining your opinion provides Nursing with a method for evaluating its practices.

You are being asked to voluntarily give your opinion on the statements in the questionnaires and in the interviews. The study involves completing 2 questionnaires and 2 taped interviews; once while in the hospital and once following discharge from the hospital. The time required to complete the questionnaire is 5 to 10 minutes and the time required to complete the interview is 10 to 15 minutes.

Your name is not on the questionnaire or on the interview form, and you may choose not to answer some or all of the questions, if you so desire, without affecting your nursing care.

I, _____ hereby consent to participate in the research study conducted by Marie Lyle.

I hereby consent to be interviewed by Marie Lyle and understand that the two (2) interviews will be recorded. I also understand that I will complete two (2) questionnaires.

I understand that I may refuse to answer any questions or that I may stop the interview at any time, without penalty. I also understand that the tapes will be kept in a locked cabinet and will be erased at the end of the study.

The information provided to the investigator may be published but my name will not be associated with the study.

I have been given the opportunity to ask whatever questions I desire and all such questions have been answered to my satisfaction.

Subject: _____

Investigator: _____

Date: _____